ABSTRACT

SOCIAL WORK

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AN ANALYSIS OF THE RELATIONSHIP BETWEEN DECOMPENSATION FACTORS AND ALTERNATIVE CARE STRUCTURES FOR MENTALLY ILL CLIENTS IN METROPOLITAN ATLANTA SINCE THE DEINSTITUTIONALIZATION MOVEMENT

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The purpose of this study was to analyze and explain the relationship between decompensation factors and alternative care structures for mentally ill clients in metropolitan Atlanta since the deinstitutionalization movement. Selected facets of decompensation and alternative care structures were analyzed to explain the impact of the independent variables on the dependent variables and to determine which of these facets are predictors of functioning and/or improved quality of life for mentally ill clients.

Survey research was utilized involving a randomly selected sample of 100 mentally ill clients who were either active participants of Community Friendship Incorporated (CFI) or residents of one of the supportive/transitional

housing programs affiliated with Community Friendship Incorporated. The independent variables for the study are age group, gender, ethnicity, education, employment and marital status. The questionnaire will employ two instruments.

The Behavior and Symptom Identification Scale (BASIS-32) allows for the documentation of self-reported functioning and symptomalogy in addition to the Alternative Care Structure Survey (ACSS) which permits self-reported documentation of usage of various program components of alternative care settings. The decompensation factors of relation to self/others, daily living skills/role functioning, depression/anxiety, impulsive/addictive behavior and psychosis; and the usage of program components of alternative care structures will be codified, measured and analyzed.

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BY

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CHAPTER ONE

INTRODUCTION

Decompensation factors, lack of utilizing and or failure to provide various program components of alternative care structures, tend to foster an environment of dependency, recidivism and chronicity among mentally ill adults attempting to reintegrate into the community. Decompensation factors are: those aspects of a person's level of functioning or symptomalogy which both define their ability to perform activities of daily living/role functioning, their ability to manage depression/anxiety without engaging in impulsive/addictive behaviors, in addition to the extent of interference from variations of psychosis. According to Issac and Armat (1990), the Joint Commission of Health and Mental Health proposed alternate care structures to provide service delivery for the chronically mentally ill in the form of: aftercare clinics, vocational rehabilitation centers, public health nursing services, foster family care, convalescent nursing homes, sheltered workshops, residential programs and partial hospitalizations. Deinstitutionalization, the federal policy which mandates community based treatment for the chronically mentally ill in the form of: vocational

rehabilitation, learning and utilizing daily functional and social skills, individual and group therapy in addition to residential placement and dispension of medication on an outpatient basis, has led to the development of alternative care structures to maintain the mentally challenged person in the community as a least restrictive measure (Johnson, 1990).

Goldman, Gattozzi and Taube (1981), as cited in Turner and Wan (1993), broadly define chronically mentally ill individuals as people who suffer severe and persistent mental or emotional disorders that interfere with their functional abilities in relation to such primary aspects of life as activities of daily living, role functioning, and interpersonal relationships, and that often result in multiple psychiatric hospitalizations. The Georgia State Board of Mental Health (1994) reported that according to the National Institute of Mental Health Advisory Council, approximately twenty-two percent of the adult population of the state of Georgia has experienced some form of mental health problem in a given year (Georgia State Board and National Institute of Mental Health, 1994). The full spectrum of mental disorders for these adults fall into one of the following categories (Georgia State Board and National Institute of Mental Health, 1994):

Schizophrenia Disorder	1%
Manic Depression/Bipolar Disorder	1%
Major Depression Disorder	6%
Obsessive-Compulsive Disorder	2%
Anxiety Disorder	8%
Other Categories of Psychiatric Disorders	4%

The Community Mental Health Movement, Civil Rights Advocacy, and the revolution in psychopharmacology have all contributed to the development that humane models based in the community were more appropriate than institutional care, yet comprehensive community-based psychiatric and medical care has not been implemented for most discharged mentally ill patients (Brickner, Scharer, Keen, Conanan, Savarese, & Scanian, 1990). Despite two thousand community mental health centers proposed, only eight hundred were ever funded, often without providing the full range of services required of them by law (Brickner, et al., 1990). Although there have been advances in psychopharmacology, therapeutic processes, and various methods of service delivery, rehospitalization rates continue to exist, clients decompensate, homelessness continues to present problems and family members feel overwhelmed (Issac & Armat, 1990). A study conducted in 1985 revealed that three months following the discharge of one hundred thirty-two patients from Central Ohio Psychiatric Hospital, one-third had become homeless during six months of their release which was ironic

in that Ohio's mental health system is rated as one of the top ten in the United States (Issac & Armat, 1990). A study conducted by Sands and Cnaan (1994) which followed patients after discharge from an inpatient program revealed that eighty-five percent of those hospitalized was due to decompensation.

Increasingly, family members are feeling overwhelmed while the family has become the institutional setting. It has been postulated that approximately eight hundred thousand people who suffer from schizophrenia and manic depression live with family members, mostly their parents (Sands & Cnaan, 1994). Families often admit that they have made their situation worse in terms of dealing with the legal system when attempting to obtain help for their sick loved ones (Sands & Cnaan, 1994). The law is designed to protect the mentally ill from obtaining treatment voluntarily unless he/she is considered a danger to himself or others (Johnson, 1990). A 1989 study of eighty-three families in Philadelphia in which eighteen percent reported that the only method that allowed for psychiatric treatment of their loved one, under terms of commitment, was through an exaggeration of symptoms and or behavior (Torrey, 1997).

Psychopharmacologically speaking, Thorazine, a major tranquilizer discovered in 1950 and reserpine, a synthetic derivative from the rauwolfia root prevented the behaviors such as fighting, kicking, head banging and cursing (Torrey,

1997). These drugs made it possible for the functioning of most mentally ill clients to be maintained in the community (Johnson, 1990). Phenothiazines are drugs which affect psychic function in terms of behavior and experience. These medications have been attributed to the release of many mentally ill persons into the community (Estroff, 1985). However, Gralnick (1985) disagrees that the advent of psychotropic drugs have assisted the mentally ill outside of hospital settings and cites Talbot's (1984) study in which less than fifty percent of discharged patients continue to take their antipsychotrophic medications post discharge.

According to Braden Johnson (1990), although psychotropic drugs can prevent some psychotic symptoms, they can cause long term irreversible problems. Tardive dyskinesia, a long term neurological condition occurs in the long term usage of antipsychotic medication which results in damage to the brain tissue. Not much is known about the disfiguring condition which entails involuntary and abnormal movements of the tongue, mouth, arms and legs (Johnson, 1990). In terms of therapeutic processes and service delivery, psychiatric (psychosocial) rehabilitation entails addressing clinical status, functional status and quality of life. It was developed as a means of reintegrating the chronically mentally ill person into the community (Munich & Lang, 1993).

Munich and Lang (1993) propose that in order to sustain the mentally ill person in the community, symptomatic improvement has to be continued with the usage of medications, psychotherapy, creating or improving independent living skills and interpersonal contacts through skills training,cognitive restructuring, consumer and family education. These authors advocate that the individual must be given help to obtain needed services like financial assistance and medical attention via case management and vocational rehabilitation. A study conducted in 1993 revealed that of one hundred fifty-seven clients in a psychosocial rehabilitation program, clients admitted feeling a sense of empowerment, satisfaction in their social interactions with families and friends, enjoyable social relations, recreational activities, vocational activities and their health (Rosenfield & Neese-Todd, 1993). Findings from a two-year outcome study of psychosocial rehabilitation of Black patients with chronic mental illness, results showed that all thirty-two patients experienced significant improvement in treatment compliance (Baker, Stokes-Thompson, Davis, Orlando, Gonzo, & Hishinuma, 1999).

Critics argue that psychiatric illnesses and institutionalization developed in our society primarily as a response to public disorder. It came into being as a sociopolitical problem; the defense of the healthy and working community against elements that would not conform to

its modes of behavior and rules of efficiency (Basaglia, 1992). According to Braden Johnson (1990), residents of the American colonies conceptualized the plight of the poor as God's righteous punishment for wrong doing and in that manner, the care of these unfortunate victims residing in publicly funded almshouses was intended to be punitive (Johnson, 1990). Basaglia (1992) reports, "isolated care and treatment justified the segregation and containment of the ill who were considered less for their illness than their potential as disruptive elements." This focus on abnormality and deviance, especially social disruption, meant that subjective suffering was not addressed, nor were the various environmental factors giving rise to psychiatric problems (Basaglia, 1992).

Basaglia(1992) further argues, "despite decades of public concern and specific legislation opposing this approach, scientific theories, professional bodies and institutions have revisited abandoning the provision of a style of care that protects society to the detriment of those cared for." Reasons for deviance for the "dangerous classes" range from pathological, subcultural or social unrest. These approaches place blame psychologically and are used to explain deviant or pathological behaviors (French, 1987). Deinstitutionalization as a policy and the resulting community programs which have developed in response from the mass discharges from state facilities

since the installation of the Mental Retardation Facilities and Community Mental Health Centers Act of 1963, has been a controversial subject among clinicians, academicians and policy makers for the past thirty years (Okin, 1995). Menial planning, inadequate funding, opposition from the community, fragmentation of services and vague terminology regarding modes of treatment and the lack of standardization among problem models are only some of the cited examples listed as explanations that deinstitutionalization has failed (Okin, 1995).

A study in England which revealed that twenty hospitalized high functioning chronic schizophrenic patients were vocationally employed and had adjusted well to the community, initiated the deinstitutionalization of at least ninety-two percent of psychiatric patients in the United States (Torrey, 1997). Regarding case management as a method of ensuring service delivery or reducing rehospitalization rates, Chamberlain and Rapp (1991) and Netting (1992), after extensive literature review of studies, state that case management is not a standardized mode of service delivery (Sands & Cnaan, 1994). Sands and Cnaan (1994) conducted a study in which two modes of case management were compared and contrasted; Community Treatment Teams and Intensive Case management Teams. Results revealed that both groups of patients were hospitalized at the same rate. Biophysical explanations have shed some light on the

mystery of mental illness. However, relying on variations of psychotherapy, psychotropic medications and hospitalizations do not in and of themselves assure that the mentally ill will experience the quality of life that others enjoy.

Recent overviews of the deinstitutionalization policy have not examined the historical and contemporary role of the hospital. Paternalism and autonomy are two different idealogies with their own clinical practices which have an affect on recidivism in psychiatric settings. Unfortunately, the state hospital and community services compete for the provision of care and treatment. The limits of a responsible process of deinstitutionalization are not clear (Geller, 1992).

Statement of the Problem

Decompensation factors and failure to provide and/or utilize program components within alternative care settings create problem areas under the policy of deinstitutionalization. For this reason, some authors think that this policy has failed. Deinstitutionalization, which is the policy of providing psychiatric care in alternative care settings within the community is a social, political, philosophical, medical and economic phenomenon, has failed (Johnson, 1990). Silver and Mckinnon (1993) cite several studies including their own in which a number of mentally ill people are homeless, noncompliant with medical

and psychiatric treatment, fail to utilize community programs designed to provide financial assistance or consumer education in order to avoid fragmentation of services.

"Social policy issues are constant items on the public agenda of the United States, on local, state and national levels. Nevertheless, our society does not have a comprehensive and internally consistent system of social policies, one that would be conducive to the realization of the inherent human potential of all of its members" (Gil, 1973). Gil (1973) further states that a common occurrence in the development of an exhaustive and consistent social policy system is the disjointed, parochial and piece-meal manner utilized by a broad group of the "social market place" members to change what is their perception of the flaws of society. Only through a thorough analysis of social policy can a more comprehensive array of services be designed to fit the needs of the population which it was developed to serve. Can case management, vocational, psychiatric or psychosocial rehabilitation provide the necessary treatment needed to sustain the chronically mentally ill in the community?

Should we build a better State Hospital? Are clients being as one author put it, "being trans-institutionalized?" Possible explanations that have been cited as predictors of readmission among this population of clients have tended to

focus on the inadequacy of treatment modalities for persons living in communities or the absence of community support for discharged patients (McGrew & Bond, 1995). A study conducted by Drake et al. (1994) in which compared rehabilitative day treatment to supported employment, revealed that a supported employment program could produce competitive jobs in the community; 28.3% of previously unemployed clients obtained competitive jobs in the supported employment program as compared with 8.2% in the day treatment program. A primary aim of model programs for chronic mentally ill people is to increase their control of situations and improve their decision making power (Rosenfield & Neese-Todd, 1993).

Model programs deliver a range of services such as psychosocial and vocational rehabilitation, socialization, medication monitoring and management administration, psychiatric counseling, psychoeducational groups and outreach services. These programs are linked by common principles, including approaches to treatment and service delivery that stress patients' strengths rather than their weaknesses associated with their illness (Rosenfield & Neese-Todd, 1993). Case management is a method of combining the social service and health care needs of the chronically mentally ill population (Sands & Cnaan, 1995). Bachrach (1989) argues that the term case management as it is utilized loosely in service delivery to the mentally ill

has various definitions and methods which result in a lack of standardization.

In a study conducted by Dincin, et al., (1993) on an Assertive Community Treatment Program utilized by a mental health center in Chicago which offered case management, focused on managing money, medication compliance and maintaining housing. Results showed that the utilization of in-bed days by high risk clients demonstrated that Assertive Community Treatment (a form of case management) markedly reduced the use of inpatient days by twenty-eight percent. Various types of intensive case management have been developed for the subgroup of chronically mentally ill individuals who often refuse office-based mental health services. One assumption made in case management programs is that if services are intensive enough hospital use can be dramatically reduced. However, the literature does show some studies which have an actual increase in hospital use among clients who receive case management services (Dietzen & Bond, 1993).

In a study conducted by D'Ercole, Struenin, Curtis, Millman, and Morris (1997), seventy-five of the one hundred forty-six patients in the case management group (51.4%) were rehospitalized for psychiatric services. They concluded that case management techniques do not in and of themselves decrease hospitalization rates....tailored and efficient outpatient community resources are essential.

Psychiatric rehabilitation addresses biopsychosocial catastrophe. This approach assumes that an individual has the capacity to learn, compensate and adapt; that supports are integral in exercising maximum autonomy and self direction (Munich & Lang, 1993). Regardless of studies that have demonstrated that psychiatric rehabilitation is an integral form of treatment, doubt continues to surface as to its effectiveness. One reason for its incomplete acceptance is that psychiatric rehabilitation addresses the separate domains of patient's functional and clinical states, as well as their quality of life (Munich & Lang, 1993). In addition, the belief is assumed that maintaining a satisfactory quality of life is a universal wish. For mentally ill clients the notion of rehabilitation is complex. Munich and Lang (1993) question the role of cognitive, vocational or interpersonal rehabilitation in terms of correcting disabilities and deficits.

Purpose of the Study

The chronically mentally ill population has increased as a result of the deinstitutionalization movement. It has been estimated that the rates of in patient hospitalization (which take into account rates of admission in addition to the rise in the civilian and elderly population), will stimulate an increase in admissions between fifty-seven thousand from 1986 to 2010 (Goldsmith, Manderscheid, Henderson, & Sacks, 1993). These authors propose that

admissions can be expected unless appropriate changes in terms of service delivery and access to services are mandated and implemented. Many mentally ill individuals in large cities experience difficulties in housing, employment and socialization (Beard, Malamud, & Propst, 1982). Consistent attention has not addressed these three needs (Test, 1981).

It is vital that efficient programs of services be developed that respond to the triangular needs of the mentally ill in order to decrease unnecessary readmissions. Gralnick (1985) proposes that a program that does not provide appropriate structure and efficient services in a client's earliest stage of illness builds an environment of chronicity. Alternative interventions as proposed by the federal policy of deinstitutionalization and their ability to address the triangle of needs for the mentally ill is vital to study. Alternative interventions and outcomes are the focal points of social work practice. There exists a growing body of knowledge on the needs of the mentally ill.

However, as stated earlier in the chapter, research in the area of program efficiency as related to service delivery of alternative care facilities is extremely limited (Test, 1981). These settings have increased during the last twenty years. The quality of life for a number of mentally ill patients has been severely compromised as a result of the policy of deinstitutionalization. The closing of

Georgia Mental Health Institute in July 1998 led to the transfer of patients to Georgia Regional Hospital and Milledgeville Psychiatric Hospital. A number of clients were placed in residential settings such as personal care homes and nursing homes.

In the last several years, state mental health authorities have allocated a high priority to the funding, development and operation of case management as a method of maintaining the chronically mentally ill in the community. The concept of case management has been in existence for over a decade yet there is still confusion concerning the definition of case management and its various approaches or methodology (Ellison, Rogers, Sciarappa, Cohen, & Forbes, 1995). This study is significant in that it will contribute to the existing body of knowledge of alternative care for maintaining the mentally ill in the community as a result of the deinstitutionalization policy. In addition, this study will provide current information on effectiveness of service delivery to the chronically mentally ill population.

A literature review conducted by Barton (1999), in which experimental or quasi-experimental outcome studies of psychosocial rehabilitation programs were examined, demonstrated that the characteristics and the service needs of clients with serious mental illness varied markedly throughout their life cycle and the course of their illness. This study called for research on an ongoing basis to

determine the outcome of psychosocial interventions and to predict the most effective and intensity of services (Barton, 1999). Recent data supports a policy of funding the psychosocial rehabilitation programs within the community and balancing the allocation of funds on the basis of service intensity (Barton, 1999).

Research Questions

The research questions of the study are as follows:

Question #1. What is the relationship between the age group, gender, ethnicity, education level, employment, marital status and selected decompensation factors of chronically mentally ill clients?

Question #2. What is the relationship between the age group, gender, ethnicity, education level, employment, marital status and selected alternative care structures of chronically mentally ill clients?

Question #3. Is there a relationship between decompensation factors and alternative care structures of chronically mentally ill clients?

Hypotheses

The hypotheses guiding this study are as follows:

Hypothesis #1. There is no statistically significant relationship between age group,gender,

ethnicity, education level, employment, marital status and selected decompensation factors of chronically mentally ill clients.

Hypothesis #2. There is no statistically significant relationship between age group, gender, ethnicity, education level, employment, marital status and selected alternative care structures of chronically mentally ill clients.

Hypothesis #3. There is no statistically significant relationship between decompensation factors and alternative care structures of chronically mentally ill clients.

Significance of the Study

In terms of social work policy, we must get involved on a legislative level to change laws that have served to oppress as well as suppress the mentally ill. Existing programs need to follow the missions that they ascribe to and agencies should be mandated and evaluated on a regular basis to provide quality clinical services in terms of diagnosis, treatment, rehabilitation and aftercare arrangements. In terms of planning, increased efforts should be made to diagnose weaknesses within a social work agency, and interventions targeted to address problem areas should be clear. Concise, measurable, achievable goals and

evaluations are necessary to determine the effectiveness of recommended program implementations.

In terms of social work administration, administrators and other staff members should be knowledgeable, skilled and experienced regarding program components beneficial to rehabilitating the mentally ill. Programs developed by social service administrators should comply with guidelines set forth by their own mission statement as well as the deinstitutionalization policy. In terms of social work practice, staff members need to be knowledgeable about mental disorders, medical conditions which may attribute to an exacerbation of/or cause a mental illness. Social workers should possess clinical assessment skills, counseling skills, and be able to formulate appropriate discharge plans. In addition, they should be knowledgeable of resources for their clientele who may experience difficulty with housing, employment, socialization or mental health services upon discharge.

Minn and Namerow (1991) concur that due to the rise in various restrictions on insurance benefits for mental health care and the dispersement of scarce resources by policy planners and health care administrators, it is vital to demonstrate service delivery and the level of care by agencies through outcome research.

CHAPTER TWO

REVIEW OF THE LITERATURE

The literature review provides a conceptual framework for understanding needs and service delivery patterns for the chronically mentally ill and explores several objectives related to the policy of deinstitutionalization. The first objective is to develop a brief historical background on the origin of mental illness and its treatment. The second objective is to trace the development of alternative care facilities. The third objective is to discuss how psychiatric rehabilitation (psychosocial and vocational rehabilitation) addresses a patient's clinical status, functional status, and the quality of life. The fourth objective is to demonstrate how case management bridges the gap between social service and health care needs for this fragile population. The aforementioned objectives will be explored within the framework of policy analysis.

Decompensation Factors

In terms of recidivism and clients decompensating, Turner and Wan's (1993) study revealed that an ecological framework of community could explain the relationship among recidivism and the role of the community. This framework

proposes that factors such as social unity, social networks and social disorganization influence the functional capacity of individuals (Turner & Wan, 1993). Their study which included examining six community level predictors of recidivism; resources, socioeconomic status, mental health status, chronicity, racial composition and household composition, revealed that the dominant predictor of rehospitalization was the female head of household (Turner & Wan, 1993). However, Stevens and Fisher (1999) found that the variables significantly related to recidivism were; short-stay hospitalizations, early age at onset of mental health problems, prior hospitalizations and brief periods of time in the community between admissions. Belcher (1987-1988) relates chronically mentally ill patients' inability to structure their lives outside of the hospital setting is likely to be due to the disorganization associated with their mental illness which places them in a state of disconnectedness with the community.

In a study conducted by Geller (1992) in which one hundred ninety-six state hospitals in the United States were encouraged to identify clients who were rehospitalized during that year, the mean number of admissions was thirty-one with a range from five to one hundred twenty-one. Torrey (1997) argued that the failure to obtain aftercare services resulted in decompensation and increased hospitalizations. Studies have revealed that without

medications fifty-three percent of severely mentally ill patients decompensate within ten months and eighty-five percent relapse within a five year period. Deinstitutionalization of the mentally ill has had a tremendous influence on the number of homeless persons. In a study conducted by the Task Force of the American Psychiatric Association (1990), the prevalence of severe and persistent mental illness (schizophrenia, schizo-affective and mood disorders) among the homeless population was twenty-eight to thirty-seven percent and affordable housing was an issue (Torrey, 1997).

Homelessness, alcohol abuse, illicit drug abuse, noncompliance with psychiatric treatment and medical illness treatment is also linked to the severely mentally ill population (Silver & McKinnon, 1993). In a study conducted by Silver and McKinnon (1993), one hundred sixty-seven patients who were homeless were placed in a program called Project HELP in an effort to assist clients to care for themselves and to secure housing. Results revealed that sixty percent of this population had schizophrenia; sixty-one percent had a medical condition related to neglect of self-care; twenty-five percent had abused alcohol and seventeen percent had abused illicit drugs. Only sixty-six percent accepted community placement and thirty-four percent returned to living on the streets (Silver & McKinnon, 1993).

Alternative Care Structures

Care for the mentally ill in the infancy of North America, was largely the responsibility of their family members with the assistance of the local community as the last resort (Johnson, 1990). The English Poor Laws of 1597 and 1601 mandated community leaders to enforce unwilling family members to assume care for their insane relative or place them in the local workhouse (Johnson, 1990). Institutional reform, the cyclical tradition in which the process of deinstitutionalization is richly steeped, has had several reforms in which policies or behaviors were implemented, abandoned, revisited and replaced (Johnson, 1990). During the eighteenth century, institutions cared for the mentally ill in the form of workhouses, almshouses, asylums, hospitals and finally culminated in the large mental hospitals overseen by the states (Johnson, 1990).

According to Deutsch (1937), the perceived causes for an illness determine the methods implemented for prevention and/or cure. As stated earlier in the introduction, explanations about the origin and treatment of mental illness were the result of demonic forces widespread in the early eighteenth century (Gallagher, III, 1980). Treatment was sought through religious rituals, chants, prayers and exorcisms (Dain, 1964). If the individual were believed to be possessed by a demon, physical torture such as squeezing

or scourging the body was done to extradite evil (Deutsch, 1937).

The Greek period of Enlightenment stimulated the development of the medical model and formulated the following advances: 1) acceptance of the concept that mental illness was caused by natural phenomena; 2) preliminary classification of mental illness; 3) recognition of the brain as the center of intellect; and 4) the development of specific cures in the treatment of mental illnesses (Deutsch, 1937). Hippocrates (460-370 B.C.), the Father of Medicine, defined mental illness as disproportions of the four humors in his system of humoral pathology; he believed that these humors (black bile, yellow bile, mucus and blood) had an effect on body temperature (Dain, 1964). As a result, treatment took the form of blood letting and purging. Another form of treatment was introduced by Asclepiades in Prussia (124 B.C.) who developed the rudiments of cognitive-reality therapy. Asclepiades believed that by prescribing sunlight areas it would induce concrete reality, which would eradicate delusions and fears (Dain, 1964; Deutsch, 1937).

Aretaeus, the Cappodocian, developed a system of classification. He established a basis for manic depression and melancholy. In addition, he is also accredited with diagnosing hysteria (Deutsch, 1937). Soranus of Ephesus (2nd century) and Asclepiades were also instrumental in

contributing a humanistic approach to the treatment of the mentally ill. Soranus taught that the victims of mental illness should be placed in well-lit rooms under regulated temperature setting, which were also supposed to include sanitation and comfort at its highest possible level (Deutsch, 1937). Although lacking in research and theoretical foundation, this medical model stimulated the development of public asylums for the mentally ill (Gallagher, III, 1980).

Despite advances contributed by the aforementioned period, poor and cruel treatment continued to be administered to the mentally ill in public asylums (Gallagher, III, 1980; Deutsch, 1973). According to Lecca and Callicut (1983) beatings, starvation, blood purging and caged exhibitions are examples of treatments that resumed into the early nineteenth century. As a result of these barbarian treatment practices, efforts were made to develop humane methods of care (Lecca & Callicut, 1983). The mid-nineteenth century stimulated the Mental Health Movement as it related to humane treatment for the mentally ill (Dain, 1964; Gallagher, III, 1980). This movement is accredited to the advocacy groundwork laid by Dorethea Dix. Waggenfield, Lemakau and Justice (cited in Gruenberg, 1982) hypothesize that the deplorable conditions of almshouses, asylums and jails were exposed in order to establish better care for the mentally ill.

According to Waggenfield, Lemakau and Justice (1982) institutionalization, under the guise of mental hospitals, evolved as a means of providing intensive treatment under sanitary conditions (Waggenfield, et al., 1982). Dorethea Dix believed that this procedure would rapidly return the mentally ill to society at a higher-functioning level (Gallagher, III, 1980). This process of institutionalization through state hospitals was widespread until the mid 1950s (Gralnick, 1985). The Shame of the States, Deutsch's novel (1948), exposed the deplorable conditions occurring in these state facilities. It appears that this literary piece continued the controversial issue of quality care.

Secondly, the passage of the Civil Rights Act identified and strengthened the concept of individual rights established by the preamble to the Constitution (Gralnick, 1985). Thirdly, there was the growing belief that institutionalization increased the likelihood of chronicity (Gralnick, 1985; Lamb, 1984). As an extension of this notion, community care was seen as an alternate means of preventing and curing mental illness (Gralnick, 1985; French, 1987). Johnson (1990) proposes that between the eighteenth and nineteenth century, mental illness was believed to be caused by brain lesions compounded by the ills of society and its social problems. This belief espoused the view that financially supported institutions

could provide the ideal method in order for society to correct their errors. It was believed that the asylum could create a community environment to assist patients in developing skills essential to activities of daily living and, as such, this stimulated the psychiatric rehabilitation movement (Johnson, 1990).

The first effort to provide psychiatric rehabilitation treatment in the United States took the form of three to four hours a day of leisure activities, socialization, educational and religious lectures and physical labor (Lamb, 1994). In an effort to guard against future attacks by the media or outraged citizens, attempts were made to upgrade institutional settings.

The Hillburn Act of 1947 allocated funds to build hospitals containing the general units and psychiatric ward (Gralnick, 1985; Lamb, 1984). It is believed that this step grew out of the premise of early introversion and short-term care (Lamb, 1984; Gralnick, 1985). Secondly, the Joint Commission on Mental Illness and Health called for increased improvement of state facilities (Gralnick, 1985). This piece of legislation reads as follows:

> The objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalism as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible. Therefore, aftercare and

> rehabilitation are essential parts of all service to mental patients, and the various methods of achieving rehabilitation should be integrated in all forms of services, among them day hospital night hospitals, aftercare clinics, public health nursing services, foster family care, convalescent nursing homes, rehabilitation centers, work services, and ex-patient groups. We recommend that demonstration programs for day and night hospitals and more flexible use of mental hospital facilities, in the treatment of both the acute and the chronic patient, be encouraged and augmented through institutional, program, and project grants (Joint Commission on Mental Illness and Health 1962, 1980).

However, continual controversy surrounding quality care managed to surface. Finally, the development of major tranquilizers in the 1950s and 1960s inspired hope and treatment through deinstitutionalization (Lamb, 1984; Gralnick, 1985; French, 1987). Deinstitutionalization, the federal policy which mandates the release of adequately prepared mentally ill individuals into society, grew out of several landmark decisions whose court cases focused on the criminal-minded as well as the criminal-insane (French, 1987).

In Baxtrom v. Herald (1966), the U.S. Supreme Court ruled denial of equal protection of the law in which mental patients received treatment which extinguished extended institutionalization in New York and was a precedent for the immediate transfer of patients to civil mental-health facilities (French, 1987). In Dixon v. Attorney General of the Commonwealth of Pennsylvania (1971), the U.S. Supreme Court ruled for the release of mentally ill prisoners to

civil facilities for reintegration into society and the Federal District court ruled in favor of improvements in service delivery (French, 1987).

This particular landmark case outlined the quality of care to be provided by treatment facilities which ultimately created the deinstitutionalization of the "mentally deficient class" held involuntarily by state facilities (French, 1987).

The legal requirement for the quality of care to be provided by community care is defined as providing a humane milieu, professionals as well as needed number of staff, individualized care plans and a minimally restrictive environment. In the court case of Youngberg v. Romeo (1972), rehabilitation and treatment became standard procedure of care for prisoners and the mentally ill.

Adjunct to the policy of deinstitutionalization, a social movement whose objective was to improve the quality of life for the mentally ill developed in the early 1970s (Waggenfield, et al., 1982). Their purpose was threefold:

1) to deter unnecessary rehospitalization;
2) to allow for the reintegration of institutionalized clients adequately prepared into society; and
3) to provide consistent maintenance of treatment as well as support (Waggenfield, et al., 1982).

According to Johnson (1990) the central factor that spurred efforts to reduce state hospital population was the possibility of bankruptcy if they continued to single handedly care for the mentally ill. In 1949 forty-eight state governors held a meeting to discuss new approaches to providing care for the mentally ill (Johnson, 1990).

Outcome Assessment: McLean BASIS-32

The movement towards managed care and limited financial resources have served as motivators for alternative care structures to utilize an assessment tool as a mental health outcome measure for service delivery, quality and effectiveness. The increasing costs of health and mental health care which occurred in the late 1980's and early 1990's culminated in two major changes in health care: the expansion of large for-profit health care corporations and the development of managed care industry to contain costs.

Consequently, market forces have had a substantial impact on health care, ranging from competition among providers, mergers geared toward increasing market share and the reduction of costs by a number of closing of facilities (Eisen & Dickey, 1996).

A Joint Commission on Accreditation of Healthcare Organization (JCAHO) initiative, entitled "ORYX," whose emphasis is formulating performance measurement into the accreditation process, has ruled that by June 30, 1999 all behavioral health care organizations who do not provide 24

hour provision of care are mandated to select two types of performance measures. In addition, they should have the collected data accessible for review by JCAHO surveyors upon request (McLean Reports, 1999).

Five indicators from McLean's Perceptions of Care (POC) have been approved for use by hospitals and alternative care structures who wish to meet ORYX accreditation requirements. These indicators are: 1) Access to Care; 2) Communication Received from Provider; 3) Interpersonal Aspects of Care; 4) Continuity and Coordination of Care; and 5) Global Evaluation of Care (McLean Reports, 1999).

The essential goals of outcome research has emphasized: 1) the applicability and suitability of interventions most effective; 2) identification of population subgroups for whom particular interventions are most effective; 3) description of provider and client characteristics related to particular outcomes; and 4) the identification of processes which are predictors for favorable outcomes (Eisen & Dickey, 1996). The inclusion of outcome assessment into clinical practice was derived from quality assurance, utilization and peer reviews (mandatory for hospital accreditation), review of public funding for health care and the inclusion of managed care provided networks.

The Behavior and Symptom Identification Scale (BASIS-32) was created in an effort to establish a brief thorough mental health status measure in evaluating the

outcome of psychiatric care from a consumers' perspective. The BASIS-32 is considered a measure developed for research purposes and should not substitute a clinical diagnostic evaluation. It allows for the consumer's self reported difficulty in symptomatology and function during the past week so that it can be administered at critical treatment points particularly upon intake, discharge and at follow-up. Areas of difficulty and symptomatology for the BASIS-32 survey instrument were obtained from open-ended reports given by three hundred fifty-four inpatients detailing their reasons for admission.

Problem areas were then categorized based on a factor analysis which yielded five major areas of difficulty: 1) relation to self/others; 2) daily living/role functioning skills; 3) depression/anxiety; 4) impulsive/addictive behavior; and 5) psychosis. These areas of difficulty were assessed on a Likert rating scale: 0 = no difficulty, 1 = a little difficulty, 2 = moderate difficulty, 3 = quite a bit of difficulty, and 4 = extreme difficulty (Eisen, et al., 1994).

A sample of three hundred eighty-seven (387) patients were interviewed with the BASIS-32 approximately seven (7) days after their admission to a private nonprofit psychiatric hospital and six months post discharge. The median age was 32 years with a fifty-two percent (52%)

single-marital status, fifty-one percent (51%) employed prior to admission.

Unipolar depression, Bipolar disorder and Substance Abuse disorder were the three primary Axis I diagnoses documented at thirty-two percent (32%), twenty-five percent (25%) and twenty-four percent (24%) respectively. Internal consistency of the 32-item scale was .89 with a test reliability ranging from .65 to .81 for the five factor analysis of the BASIS-32 instrument (Eisen, et al., 1994).

It is important to note that to this date, the BASIS-32 has not yet been determined as appropriate for outpatient programs. In an effort to demonstrate its applicability for an outpatient population, Eisen et al. (1999) sampled a population of four hundred and seven (407) clients in an outpatient program (3 adult outpatient clinics and 8 community mental health centers) in Boston, Massachusetts from the Fall of 1995 to the Spring of 1996.

The demographics of that sample population were as follows: fifty-five percent (55%) female, sixty-four percent (64%) between the ages of twenty-five to forty-four (25-44), ninety-one percent (91%) Caucasian, fifty percent (50%) never married and fifty-two percent (52%) were employed prior to enrolling in the outpatient program. The primary Axis I diagnosis was Depression at forty-three percent (43%) and ten percent (10%) with a Substance Abuse disorder. Follow-up was conducted at a thirty to ninety (30-90) day

interval after intake due to the literature stating that the greatest amount of improvement occurs during the early stages of treatment. Results were retained from fifty-six percent (56%) of the original sample.

When comparing respondents, there were no statistically significant differences among marital status, living arrangements, employment or diagnostic group. Females were more likely to respond; sixty-two percent (62%), $x2=7.98$ $p<.01$ and older clients tended to respond, $r=13$, $p=.01$. Respondents tended to report more difficulty at time of intake than nonrespondents (Eisen, et al., 1999).

In an effort to determine the reliability of the patient self-report versus a structured interview, Eisen (1995) used an experimental design in which patients were randomly assigned to one of three groups: 1) interview method; 2) self-report group; or 3) choice for either grouping. A sample of one hundred and fifty (150) consecutive admissions were randomly placed in one of the three groups.

Demographics of the sample revealed the following: fifty-nine percent (59%) female, mean age of 38 years old (37.8%), fifty percent (50%) single-marital status and thirty-seven percent (37%) were employed. Results of this study revealed that there were no markedly significant differences among the three assessment techniques with

respect to the rate of participation, gender, marital status, education nor employment status (Eisen, 1995).

The clients who were assigned to the "interview group" and those who chose the "interview group" were markedly older (M=42.2 yr; SD=11.1) than those who chose the "self-report group" (M=30.9 yr; SD=15.8) (Eisen, 1995).

Comparative analysis of pre- and post-tests revealed that those who were assigned to the "self-report group" reported significantly more difficulty than those who chose the "interview group" in relation to self/others (3.338, $p<.05$) and daily living skills (3.19, $p<.05$). With respect to both subscales, those who were assigned to the "self-report group" expressed more difficulty. In terms of relation to self/others, the assigned "self-report group" expressed markedly more difficulty than those clients assigned to the "interview group" (Eisen, 1995).

Theoretical Framework: Psychosocial Approach As A Method Of Providing Quality Care

According to Gil (1973) prior to a policy being analyzed in conjunction with a theoretical framework of reference, its provisions should be specified. Gil (1973) proposes that, "if the policy has already been enacted into law, administrative regulations and judicial decisions concerning it should be taken into consideration along with the language of the law... A valid model of social policies facilitate analysis of specific social policies and their

consequences, and aid in the development of alternative social policies" (Gil, 1973).

> In trying to cope with complex realities, human societies have created stark divisions between the good and the bad, the safe and the unsafe, the friend and the enemy. It is a curious fact that greater attention is invariably paid to the negative poles of the dichotomy; to the bad, the unsafe, the enemy. This pull toward the negative aspects of life has given peculiar shape to human endeavors and has, in...helping professions, created a profound tilt toward the pathological (Sullivan, 1992).

A pathology based or deficit bearing approach has interfered with the promotion of maximum community integration. Erickson's psychosocial approach incorporates the interrelatedness of the biological, social and psychosocial components as they relate to human growth (Kirst-Ashman & Zastrow, 1994).

These components are linked in such a manner that a person's strengths, weaknesses, limitations, potentials and systems within which they interact are completely assessed (Bachrach, 1992). On this knowledge base are developed skills in engaging responsibly and effectively in a therapeutic and helping relationship with individuals, families, groups and significant environments to bring about planned change in human functioning (Kirst-Ashman & Zastrow, 1994).

Sullivan (1992) argues that community services cannot adequately determine the successful reintegration of the mentally ill to the community. These individuals need to

obtain work, have families, friends, socialization and recreational activities (Sullivan, 1992).

The Biopsychosocial model of mental illness and functioning created the premise for the goals of psychiatric rehabilitation which address clinical status, functional status and the quality of life (Munich & Lang, 1993). Lamb (1994) concurs that psychiatric rehabilitation should entail building upon the mentally ill person's strength, improving vocational and social abilities, integrating the various environmental aspects of the person's life and instilling a sense of empowerment and transformation (Lamb, 1994). Psychiatry has focused on the clinical status, rehabilitation has focused on the functional status and social work (case management) has focused on the quality of life (Munich & Lang, 1993).

According to Lamb (1994), there was an emphasis in the early twentieth century on the understanding of the social environment and biological factors in examining psychopathology by Adolf Meyer, the founder of modern psychiatry. In addition, Meyer requested that psychiatrists work with the healthy portion of the mentally ill person's personality.

Prior to the 1943 amendments to the Vocational Rehabilitation Act in which provision of services were mandated for the psychiatrically disabled, Thomas Eddy (1815) wrote, "of all the modes by which maniacs may be

induced to restrain themselves, regular employment is perhaps the most efficacious... The patient should always be treated as rational a being as the state of his mind will possibly allow" (Munich & Lang, 1993).

During the contemporary period of psychiatric rehabilitation which is recognized as the 1970's, there was a culmination and definition of the attitudes, technology, in addition to the philosophy necessary to provide psychiatric rehabilitation (Beard, et al., 1982). The belief that each patient was an individual with their own special interests, needs, abilities and resources was derived from Wing and Anthony (Munich & Lang, 1993). Liberman espoused the view that generic skills were essential to increase personal effectiveness, to conduct roles, to create and maintain rewarding relationships. This perspective emphasized methods necessary to maintain schizophrenic clients relearn or learn social and personal skills while residing in the community through clear structured training with the use of psychotropic medications (Munich & Lang, 1993; Lamb, 1994).

Olansky (1968) as cited by Lamb (1994) contributed two major developments to the field of psychiatric rehabilitation by pointing out in his study that there was no evidence among work functionality nor the degree of emotional wellness and that people do not have to be

socialized prior to being able to function in their work environment.

The psychosocial club movement was developed by John Beard in 1942. Beard proposed that the chronically mentally ill have more functional capabilities than is believed or recognized by professionals and as a result should be allowed all possible opportunities to enhance their capacities to reside in the community (Lamb, 1994). These psychosocial club programs initiated by Beard (1948) offer prevocational day programs, transitional employment, evening and week-end services, socialization, supported housing, hospital and community outreach (Lamb, 1994).

Although Fountain House reports that their model was uniquely developed, some of their beliefs are similar to the psychosocial approach. Fountain House's philosophy is to provide an integrative community designed to develop a restorative environment within which individuals who have been socially and vocationally disabled by mental illness can achieve or regain the confidence and skills necessary to lead lives in which they can be productive, contributing citizens and enjoy social relationships (Beard, et al., 1982).

Bachrach (1992) cited eight basic beliefs essential to the field of psychiatric or psychosocial rehabilitation:

1) The primary goal was to allow a person to develop their full potential;

2) The role of environmental factors were essential in that a person should be assisted to adapt or the environment should change according to a person's needs;

3) A client's strength should be acknowledged, developed and encouraged;

4) The goal of restoration;

5) Optimism about the vocational potential;

6) Socialization and recreation;

7) Involvement in their own care; and

8) Continuous improvement.

The Vocational Rehabilitation Act of 1973 which mandated individualized written rehabilitation program demonstrated an emphasis away from the symptoms and a birth of empowerment through advocacy and transformation which was the ultimate foci of social work practice. Aquila, Santos, Malamud, & McCrory (1999) found that work was perceived as a therapeutic method, an identifier of citizenry and a source for financial independence. Vocational interventions include, industrial therapy, sheltered workshops, transitional employment, projects with industry, supported work, volunteer work and competitive placement in the workforce (Bond, Drake, Mueser, & Becker, 1997).

Kasper, Steinwachs and Skinner (1993) argue that employment is a vital opportunity due to direct improvements in activity, social contracts, renumeration, and an increase

in one's self esteem and quality of life (Drake, Becker, Biesane, Torrey, McHugo, Wyzik, 1994). Drake, et al., (1994) found that on a national level, three percent of people with severe mental illness have been in supported employment and the actual rates of vocational assistance and vocational success are quite minimal.

Anthony and Blanch (1987) found that less than fifteen percent of severely mentally ill clients are employed at any one time. The poor financial and administrative support have contributed to a range of problems that have impacted vocational rehabilitation entail: a lack of standardization of rehabilitative services; a lack of consensus relating to the appropriateness of rehabilitative goals coupled with menial research on outcomes.

The restorative environment mentioned in the Fountain House model was referred to as the therapeutic milieu specified in the psychosocial model. Both models share the potential ability of different components to work together in an effort to increase the functional level of the mentally ill. It also appears that these models shared the same value orientations:

1) an optimistic view of human potential;
2) optimistic view of human worth; and
3) improvement in the quality of living (Anthony & Blanch, 1987; Zastrow & Kirst-Ashman).

The Fountain House model structures its program so that participants feel that (1) they belong, (2) are needed and (3) are wanted (Beard, et al., 1982). First, the name of the club denotes a warm, accepting atmosphere. Here in Atlanta, Georgia, the name of the program is "Community Friendship." The term "Club House" means membership, a place where one belongs and is regarded as a far more enabling designation; one that creates a sense of the participant's belonging, and belonging to a vital, significant society to which one can work together with fellow members in all of the activities that make up the club house program (Beard, et al., 1982).

Various program components such as clerical functions, grocery purchases, food preparation and other maintenance activities are performed by staff and members working together (Beard, et al., 1982). Similarly to the psychosocial model, the Fountain House model is also concerned with the well-being of the person. Within the clubhouse, members have available to them a comprehensive array of opportunities, including but not limited to: 1) daytime work-organized activities focused on the care, maintenance, and productivity of the clubhouse; 2) evening, weekend, and holiday leisure time activities; 3) substantial transitional and independent employment support and efforts; and 4) a wide range of housing options (Aquila, et al., 1999).

According to Ellison, et al. (1995), one of the objectives of model programs for the chronically mentally ill is to increase the person's level of control in various situations by improving their ability to make decisions. Model programs provide a variety of services; psychiatric treatment, psychosocial and vocational rehabilitation, supervision, social contacts, various activities and services to meet primary needs. The theoretical approach which guide these programs are an emphasis on client's strengths as opposed to weaknesses associated with their mental illness (Ellison, et al., 1995).

Rehabilitation has an emphasis on empowerment in terms of perception of personal control essential to quality of life (Rosenfield & Neese-Todd, 1993). Rosenfield and Neese-Todd (1993) conducted a study whose findings indicated that the perception of empowerment in lieu of the program's methodology was highly related to members' satisfaction with their:

1) living arrangements;
2) social relations;
3) family relations;
4) prevocational activities;
5) safety;
6) health; and
7) leisure activities.

In order to assist the mentally ill to successfully transition in their return to the community, case management was developed. Many different approaches to case management exist but they can be categorized in terms of their similar goals and methodology. The definition of case management as practiced in the service delivery of long-term mentally ill patients does not have a universal standardized approach to date (Bachrach, 1993). Although it is not a standardized form of service delivery, it is a technique of integrating and providing the social service and health care need of the chronically mentally ill (Bachrach, 1993).

Currently, four models of case management exist:

1) the expanded-broker model dictates that case managers are responsible for identifying client's needs and coordinating existing services but not necessarily providing direct treatment services;
2) the personal-strengths model dictates that the case managers should assess their clients' strengths and weaknesses in addition to fostering situations in which clients can utilize their strengths to attain personal accomplishments by gaining access to needed services, i.e.... vocational training, housing, socialization and medical attention;
3) the rehabilitation model emphasizes assessing deficiencies and teaching clients the skills

necessary to decrease if not eliminate deficits; and

4) the full-support model received the most attention by researchers, case managers provide direct care as well as gatekeepers of needed services such as income in addition to the services given by those case managers utilizing the personal-strength model (Clark & Fox, 1993).

Case management and rehabilitation emphasize the necessity to create a "person, place or thing" to support an individual's functioning (Munich & Lang, 1993). These two interventions are concerned with the individual's environment, role choice and resources such as family, housing or entitlements. They attempt to provide or coordinate supports in conjunction with what the person wants, needs and can utilize (Munich & Lang, 1993). Case management interventions stress providing access to resources, supports and opportunities (Munich & Lang, 1993).

Rubin and others (1987) argue that case management is essentially a boundary spanning technique that connects persons to a cluster of direct service providers (Sands & Cnaan, 1994). Harris and Bachrach (1988), and Rapp and Winterstein (1989) emphasize the provision of direct service (Sands & Cnaan, 1994). Case management services are conducted in a number of ways: due to high risk populations; by teams of workers or individual case managers; with or

without the provision of counseling; with frequent contacts; and by a wide range of mental health professionals (Moore, 1990).

Currently, several typologies of case management are in the literature and quite possibly may be attributing to the fragmentation of services and recidivism due to the lack of standardization. According to the Mental Health Policy Resource Center, four models of case management are: the Broker model, Personal Strengths model, Rehabilitation Case Management model and Assertive Community Treatment model (Chamberlain & Rapp, 1991).

Various dimensions are utilized to differentiate between the models of case management; philosophy, assessment methods, sites of service, staff composition and hierarchy, staff-client ratio, roles and functions of the case manager, length of time of client-staff relationship, credentials of the case managers and high risk population (Ellison, et al., 1995).

Korr and Cloninger (1991) classified three types of case management services by their degree of comprehensiveness: Minimal model, Coordination model and Comprehensive model. Minimal model consists of outreach, client assessment, case planning and referral to service providers. Coordination model includes those services in the minimal model in addition to client

advocacy, case work, creating natural support systems and reassessment.

The Comprehensive model is inclusive of the processes in the minimal and coordinator model in addition to advocacy for resource development, quality monitoring, public education and crisis intervention (Sands & Cnaan, 1994). The various models of case management although different in conceptualization and program or service delivery, are not different in clinical practice.

Solomon (1992) identified and described four similar models of case management and found that varied methods are successful in reducing the number and length of rehospitalizations, decreasing costs and enhancing the client's quality of life. Curtis, Millman and Struenin (1992) found that case management programs increased hospital use among clients who receive case management services, Sands and Cnaan (1994) found that case management has been shown to be an asset in improving subjective reports of the quality of life, a deterrent in the increase of hospitalization rates and a vital aspect of maintaining the client in the community.

Summary of the Literature

In summary, extensive research reveals conclusively that there exists a growing body of knowledge on needs assessment for the mentally ill. However, little research has been developed in the area of program evaluation in

agencies serving the needs of the mentally ill. An historical analysis has shown that methods of caring for the mentally ill have been a continual issue for the field of mental health. It is this researcher's hope that this study will contribute to program efficiency in serving this growing population.

CHAPTER THREE

METHODOLOGY

This chapter presents the methods and procedures that were employed to conduct the study. It describes the research design, study site, sample and population, instrumentation and the data collection process in addition to the treatment of data.

Research Design

The research design selected utilized an explanatory survey to study decompensation factors and use of alternative care structures among the mentally ill clients in metropolitan Atlanta. Surveys can be employed for explanatory, descriptive or exploratory usage and in addition, they are primarily utilized in studies for which the unit of analysis are individual people (Babbie, 1995).

A survey research design is an optimal method for collecting original data for a large population that is difficult to directly observe (Babbie, 1995). The study explores and describes in order to explain the relationship between decompensation factors and usage of program components of alternative care structures in addition to the

client's perception of their level of functioning and symptomalogy.

The study analyzed five facets of decompensation factors (relation to self and others, daily living skills/role functioning, depression/anxiety, impulsive/ addictive behavior and psychosis) as identified in the BASIS-32 (Eisen, et al., 1996). The five facets above were analyzed in conjunction with the four facets of alternative care structures (mental health center, biopsychosocial programs, residential facilities and vocational rehabilitation programs) in order to explain the relationship between age group, gender, ethnicity, marital status, education level and employment status of the clients under the study.

The Statistical Package for the Social Sciences (SPSS) as introduced by Babbie (1995) was used to process and analyze the data. Specific procedures were:

1. Descriptive statistics utilizing frequency analysis which allowed for the distribution of cases in a given analysis; each outcome was observed in the sample and present a demographic profile of the typical client presented;
2. Cross tabulations were used to display the combined frequency distribution which is the observed occurrence of two discrete variables;

3. Pearson's Correlation Coefficient was utilized to determine the association between two variables approximating the direction and strength of a linear relationship between those two variables and the Chi-Square test was used to test for significance at the .05 level; and
4. Linear Regression was used to determine the strength of the association between the variable in a linear form and to obtain the coefficient of determination to determine which independent variables are predictors of which decompensation factors and alternative care structures.

The study identified seven (7) independent and nine (9) dependent variables. There are seven (7) independent variables which are: 1) gender, 2) ethnicity, 3) age group, 4) income, 5) employment, 6) marital status, and 7) education level. These were used because they appear to be predictors of usage and or participation in mental health services.

There are nine (9) variables which were utilized as dependent variables because they fall under the categories of decompensation factors and alternative care structures. The author believes that these variables can predict how well a client reintegrates into the community.

Facets of decompensation are: 1) relation to self/others, 2) daily living skills, 3) depression/anxiety, 4) impulsive/addictive behavior, and 5) psychosis. Facets of alternative care structures utilized in this study are: 1) mental health center, 2) biopsychosocial program, 3) residential facility, and 4) vocational rehabilitation.

Description of the Site

Community Friendship Inc., is a nonprofit biopsychosocial program which is located in metropolitan Atlanta, Georgia. It is easily accessible by local public transportation. The goal of the organization is to provide psychiatric rehabilitation in terms of housing, financial assistance, socialization, educational and vocational assistance internally as well as working in collaboration with other agencies.

The center boasts a Day program in which members are encouraged to develop vocational skills which can be transferred to the employment arena; a Socialization program in which social interaction is viewed as an integral component of transitioning back to the community; the Transitional and Supported Employment program assists members in securing jobs or competitive employment and lastly the Case Management program that assists members in accessing needed services.

Sample and Population

An alphabetized listing of clients who have been active members for the last two years (1997-1999) in the Day program, Socialization program or Employment program in addition to residents at one of the Supportive/Transitional Housing affiliates of Community Friendship Incorporated will be utilized as the initial sampling frame. From this frame a random sample of one hundred individuals from the Adult Services Unit of a Fulton County Mental Health Center will be assigned numbers so that every fifth person will be used for case analysis.

One hundred clients were chosen as the sample size for this particular study because it was proposed by the executive director that this sample size would give an accurate estimate of the functional level of the clients due to the wide range of illness, severity and capabilities of this population.

The study's population consisted of adult persons who were diagnosed as mentally ill and were residents of Fulton County. As stated in the introduction, mental illness is defined by one of three criteria: 1) diagnosis, 2) disability, and/or 3) duration. This population encompassed various races, gender, social economic status, type and length of illness. Georgia Regional Hospital is an acute care psychiatric hospital which provides inpatient psychiatric services for residents of the counties of

Dekalb, Fulton, Cobb and the North Georgia region. Referrals are generally made to alternative care structures like Community Friendship, Inc., and the local mental health center in order to assist the client in returning to the community to receive needed services.

Instrumentation

The Behavior and Symptom Identification Scale (BASIS-32) is a survey questionnaire which was created to provide a brief but exhaustive mental health status measure to be utilized in assessing the client's perception of psychiatric care (Eisen, et al., 1996). The BASIS-32 was selected because it allows for the self-reported documentation of a client's level of functioning and symptomalogy which can be administered at various intervals of the treatment process (Eisen, et al., 1996).

According to Eisen, et al. (1996), the paradigm shift of health care reform from a service to a business has established a total quality management (TQM) aspect towards the improvement of products/services and a substantial concentration on client satisfaction and involvement in assessing quality.

The primary essential aspects of the BASIS-32 which distinguish it from various outcome measures, include information regarding level of functioning and symptomalogy was collected and codes based on acutely ill patients' perception during an inpatient hospitalization and presents

an individualized and standardized method for assessment (Eisen, et al., 1994).

Currently, four characteristics differentiate the BASIS-32 from other outcome measures. First, the categories and answers were obtained from the patient's point of view. Secondly, it was created on an in patient ward with clients in an acute stage of their illness. Thirdly, it entails all psychiatric symptomalogy and functioning levels in one measure. Lastly, it includes methods for assessing patients (Eisen, et al., 1994).

The scale was tested for reliability and validity utilizing pre and post test scores, test-retest reliability and found to be comparable to those reported for similar measures. In addition, BASIS-32 suffers from a lesser degree from lacking in discriminant and convergent validity because it has been reported that three of the five subscales (relation to self/others, depression/anxiety and daily living/role functioning) were moderately intercorrelated.

The other remaining scales (impulsive/addictive behavior and psychosis) were relatively independent from each other and the other three. Since the validity and reliability of the BASIS-32 has been established, the accuracy of measurement and the consistency of measurement of this study using the BASIS-32 and ACSS will be generated after the survey.

The Questionnaire

A frequency distribution for the five decompensation facets (relation to self/others, daily living skills/role functioning, depression/anxiety, impulsive/addictive behavior and psychosis) will be computed as follows (see questionnaire):

1. Relation to self/others: Items (#7+#8+#10+#11+#12+#14+#15)
2. Depression/anxiety: Items (#6+#9+#17+#18+#19+#20)
3. Daily living/role functioning skills: Items #1(#2+#3+4)+#5+#13+#16+#21+#32. Items 2, 3 and 4 are used to create one "role functioning score" by taking the highest of the three ratings which indicates the greatest difficulty.
4. Impulsive/addictive behavior: Items (#25+#26+#28 +#29+#30+#31).
5. Psychosis: Items (#22+#23+#24+#27).
6. BASIS-32 average: Items 1-32

An additional instrument entitled, "Alternative Care Structure Survey" (ACSS) created by Robert Waymer (2000) and this researcher and was utilized because it allowed for an analysis of the usage of various program components and selected decompensation factors.

The ACSS employed the same Likert scale to allow for simple analysis and comparison when examining various facets of decompensation factors and alternative care structure

usage which was the focal point of this particular study. The ACCS was used in conjunction with the BASIS-32 because they shared the same scale: 0 = no difficulty, 1 = a little difficulty, 2 = moderate difficulty, 3 = quite a bit of difficulty, and 4 = extreme difficulty.

This allowed for the analysis of selected alternative care structure usage when comparing selected decompensation factors which was the focal point of this particular study. Calculation of decompensation factors: 1+2+3+4+5/5= Decompensation Score (BASIS-32 Average)

A frequency distribution was completed on the alternative care structure variables (mental health center, biopsychosocial program, residential program and vocational rehabilitation) and was computed as follows (see questionnaire):

1. Mental health center: Items (#44+#45+#46)
2. Biopsychosocial program: Items (#47+#48+#49)
3. Residential facility: Items (#50+#51+#52)
4. Vocational rehabilitation: Items (#53+#53+#55)

Calculation scores: 1+2+3+4/4 = alternative care structure survey score.

Cross tabulations were done on the six independent variables (age group, gender, ethnicity, education level, employment status and marital status) with the dependent variables alternative care structure and decompensation factors. This measurement was done in order to reveal the

strength of the relationship between the independent and dependent variables.

The statistical test used was the chi-square test which tested for (Pearson's) significance at the .05 level of probability. Regression and correlation analysis were done in order to determine the coefficient of determination (R). This test indicated the explanatory power of the analysis and the strength of association between the decompensation facets,alternative care settings and the dependent variables.

The correlation indicated which decompensation facet and alternative care facet was the best predictor of the dependent variables. The test statistic for this analysis was the F-ratio at .05 level of probability. The hypotheses of the study was tested for statistical significance at .05 level of probability. Alternative care structure definitions include the following:

1) Mental Health Center - after care agencies which provide the following but are not limited to:
    a) clinic visits - appointment with case managers in the form of Social Workers, Professional Counselors Nurses and Psychiatrists.
    b) obtaining medications - dispension of psychiatric medications through indigent programs or with the assistance of the medicaid program.

c) psychotherapy - therapy sessions with the psychiatrist to monitor medications and assess level of functioning.

2) Biopsychosocial Center - agencies which provide prevocational programs in addition to consumer education essential to assist the client readjust to the community and manage their illness. These agencies also provide the following programs but are not limited to:

a) Day program - clients can learn and or develop skills in the arena of clerical work, food service, maintenance and environmental service and utilize these skills in a work setting.

b) Socialization - a program component which offers a wide variety of social and recreational activities aimed at managing stress and enabling social interaction with others.

c) Employment - this facet allows clients to be assisted and or placed in jobs which take the form of transitional employment, supported employment, competitive job placement or a volunteer job.

3) Residential Facility - provision of living arrangements.

a) Group Home - a residential facility conducive for clients who need extra assistance with responsibilities and cannot financially manage or

take care of themselves mentally in an independent setting.

b) Personal Care Home - similar to a group home setting and medications, meals, laundry and other needed services are provided to the client who cannot independently provide for their needs.

c) Independent Living - residential programs in which clients are fairly independent in terms of managing finances, completing activities of daily living and supervising their own medications.

4) Vocational Rehabilitation - programs that are designed to assist clients in the area of:

a) Work - transitional, supported, competitive or volunteer.

b) Counseling - in terms of exploring level of functioning in order to place in a work setting conductive to their ability to perform.

c) Training - various programs in which clients receive attention from a job coach in performing work related duties and also receive emotional support for as long as they remain employed to monitor progress and/or areas of difficulty.

A memorandum from the Georgia Department of Human Resources (May 1999) ordered all hospital and alternative care settings to utilize this measure to determine outcome

assessments in addition to up-grading their method of service delivery starting January 2000.

Treatment of the Data

For the protection of human subjects, clients were assigned a confidential coded number from one to three digits so that they could not be recognized but their responses to the survey could be utilized for the purpose of analysis. The researcher obtained verbal permission from the Executive Director of Community Friendship, Inc. Clients were given a verbal and written introduction regarding the purpose of this research project and the questionnaire was administered by the researcher and kept in a confidential folder.

Limitations of the Study

Limitations of the study entail that the questionnaire was administered to clients who had been active with Community Friendship, Inc. for two years. An additional limitation was the lack of a secondary data sources and questionable applicability and utility of the BASIS-32 as an outcome assessment predictor such as a medical record to verify responses.

The final limitation of the study is that the BASIS-32 was developed to assess mental health outcomes among an inpatient population and its applicability and utility for an outpatient population has not been evaluated.

Nevertheless, Eisen et al. (1999) believe that this particular instrument should be utilized on outpatient population and has utility with this particular type of program.

CHAPTER FOUR

FINDINGS

This chapter contains findings from the study. It presents the characteristics of the sample population and an analysis of the data obtained from the questionnaire. The findings are divided into three sections: demographic data, research questions, and hypotheses.

A total of one hundred clients of the Community Friendship, Incorporated and residents of their transitional/supportive housing program in the metropolitan Atlanta area were surveyed. The sample was drawn from over five hundred clients who were either currently active in Community Friendship Day Program, Socialization Program, Transitional Employment Program, or residents of Supportive Living Program.

Demographic Profile

The study sample was comprised of one hundred individuals who were currently active in the day program at Community Friendship or were residents of one of the residential facilities affiliated with Community Friendship, Incorporated.

Approximately sixty-two percent of the sample population were African American, thirty-five percent were Caucasian with a reported one percent Asian and two percent of American Indian heritage. Fifty-five percent of the participants were males.

Forty-three percent of the population were between the age range of thirty-five to forty-four years of age, followed by twenty-five percent in the age range of forty-five to fifty-four years of age. Thirty-eight percent of the sample had completed high school or received their GED. Twenty-five percent had attended some college while ten percent had a college degree.

As previously indicated, the primary purpose of this study was to determine if there was a statistically significant relationship between decompensation factors and alternative care structures of mentally ill clients in the metropolitan Atlanta area. This chapter describes the statistical analysis utilized to test the hypothesis which were formulated from the research questions in chapter one, and it is divided into two sections. Section one describes the demographic data, and research questions and hypotheses.

Demographic Data

This section provides a profile of the study respondents. Descriptive statistics were used to analyze the variables. Table 1 contains a demographic profile of the independent variables. It shows the association between

the independent variables of the mentally ill clients in the metropolitan Atlanta area.

Table 1

Number and Percentage of Sample Demographic Variables (N=100)

Variable	N	%	Cum %
Race			
African American	62	62.0	62.0
Caucasian	35	35.0	97.0
Asian	1	1.0	98.0
American Indian	2	2.0	100.0
Gender			
Male	55	55.0	55.0
Female	45	45.0	100.0
Age Range			
Under 25	4	4.0	4.0
25 - 34	14	14.0	18.0
35 - 44	43	43.0	61.0
45 - 54	25	25.0	86.0
55 - Over	14	14.0	100.0

Table 1 (continued)

Variable	N	%	Cum %
Education			
8th Grade or Less	11	11.0	11.0
Some High School	16	16.0	27.0
H.S. Graduate or GED	38	38.0	65.0
Some College	25	25.0	90.0
4 Year College Graduate	10	10.0	100.0
Marital Status			
Never Married	57	57.0	57.0
Married	8	8.0	65.0
Separated	6	6.0	71.0
Divorced	22	22.0	93.0
Widowed	5	5.0	98.0
Missing	2	2.0	100.0
Living Situation Within The Past 30 Days			
Alone	22	22.0	22.0
Halfway House, etc.	35	35.0	57.0
With Family	16	16.0	73.0
With Non-Relative	14	14.0	87.0
Other	9	9.0	96.0
Shelter/Street	3	3.0	99.0
Missing	1	1.0	100.0

Table 1 (continued)

Variable	N	%	Cum %
Working At A Paid Job Within The Past 30 Days			
Yes	37	37.0	37.0
No	63	63.0	100.0
Number Of Hours Worked During The Week			
Not Working	54	54.0	54.0
1 - 10 Hours	13	13.0	67.0
11 - 20 Hours	21	21.0	88.0
21 - 30 Hours	9	9.0	97.0
30+ Hours	2	2.0	99.0
Missing	1	1.0	100.0
Students Currently in Training or Academic Programs			
Yes	15	15.0	15.0
No	85	85.0	100.0

Table 1 indicated the typical client in the study was an African American male, 35 to 44 years of age, and had a high school diploma. As well, the typical consumer had never been married, lived in a supportive dwelling residence, had not been employed in the past 30 days, nor

had he worked or attended any type of academic/vocational program within the past 30 days. As shown in Table 1, 62 or 62 percent of the clients were African Americans, 35 or 35 percent were Caucasians, 1 or 1 percent were Asian, and 2 or 2 percent of the respondents were American Indians. These percentages indicated that more African Americans responded to the questionnaire.

The majority of the respondents were males as indicated in Table 1; of the 100 clients, 55 or 55 percent were males and 45 or 45 percent were females. As previously indicated, the majority of the respondents were in the 35-44 age range, four or 4 percent were under age 25, while 14 or 14 percent were in the age range of 25-34. Forty-three or 43 percent were in the 35-44 age group, 25 or 25 percent were in the age group of 45-54, and 14 or 14 percent of the respondents were in the age group of 55 or over, respectively.

Table 1 revealed that the majority of the respondents had either some high school training or graduated from high school or had obtained a general equivalency diploma. Sixteen or 16 percent of the respondents had completed some high school, 38 or 38 percent had completed high school or the requirements for the general equivalency diploma, and only 11 or 11 percent had an eighth grade education or less. Twenty-five or 25 percent of the clients had completed some college courses, followed by 10 or 10.0 percent of whom held a bachelor's degree.

More than half of the respondents had never been married, and less than a third were divorced. Table 1 indicated that 57 or 57 percent had never been married; 8 or 8 percent were married; 6 or 6 percent were separated from their spouse; 22 or 22 percent were divorced and 5 or 5 percent were widowed.

Regarding living arrangements, the majority of the respondents reside in a supportive living residential facility. Table 1 indicated that 22 or 22 percent of the respondents dwelled in independent living; 35 or 35 percent lived in supportive housing; 16 or 16 percent lived with family members; 14 or 14 percent lived with non-relatives; 9 or 9 percent resided in other types of housing, and only 3 or 3 percent resided in a shelter.

The majority of the respondents had not worked in paid employment thirty days prior to completing the questionnaire. Table 1 indicates 63 or 63 percent of the respondents had not been employed in the previous thirty days, while 37 or 37 percent had been employed prior to completing the questionnaire.

Concerning work during the past week, 54 or 54 percent stated that they had not worked during the week. Table 1 indicates 13 or 13 percent had worked 1-10 hours during the past week; 21 or 21 percent of the respondents had worked 11-20 hours a week prior to answering the questionnaire; 9 or 9 percent had worked a total of 21-30 hours, followed by

2 or 2 percent who worked 30 or more hours during the week prior to answering the questionnaire.

As indicated in Table 1, the majority of the respondents had not attended college or any type of vocational training program during the past thirty days prior to completing the questionnaire. Eighty-five or 85 percent had not attended any type of training or academia within the past thirty days, followed by 15 or 15 percent who indicated that they had been enrolled in vocational training or academia within the past thirty days as indicated in Table 1.

Decompensation Factors

Decompensation factors are aspects of an individual's level of functioning or symptomalogy which defines both their ability to perform, activities of daily living/role functioning and their ability to manage depression/anxiety without engaging in impulsive/addictive behaviors in addition to the extent of interference from variations of psychosis.

Relationship to Self and Others

This particular facet of decompensation is defined as an individual's perception of how they relate to others and their perception of themselves to the world around them.

Table 2

Relationship to Self/Others of Chronically Mentally Ill Clients (N=100)

Variable	Number	Percentage
Relation to Self and Others		
No Difficulty	55	55.0
A Little	23	23.0
Moderate	17	17.0
Quite A Bit	1	1.0
Extreme	1	1.0
Missing	3	3.0

Table 2 revealed that fifty-five percent of the sample denied having any difficulty in getting along with others or with their perception of themselves with others. More than half of the population reported that they got along well with family members and others. Twenty-three percent of the sample reported having a little difficulty getting along with others or feeling comfortable with themselves, while seventeen percent reported a level of moderate difficulty.

Daily Living Skills

This facet of decompensation is defined as an individual's ability to complete activities of daily living

inclusive of grooming skills, laundry, cooking, shopping, and caring for themselves.

Table 3

Daily Living Skills of Chronically Mentally Ill Clients (N=100)

Variable	Number	Percentage
Daily Living Skills		
No Difficulty	61	61.0
A Little	18	18.0
Moderate	15	15.0
Quite A Bit	4	4.0
Extreme	2	2.0
Missing		

Interestingly, table 3 revealed that sixty-one percent reported no difficulty in functioning in activities of daily living, which includes cooking, laundry, handling money, or making decisions, to name a few examples. More than thirty-three percent reported a little difficulty and a moderate level of difficulty in this area. Only six percent reported that they experienced quite a bit or an extreme level of difficulty with this area of functioning.

Depression and Anxiety

This facet of decompensation refers to periods of hopelessness, low energy level, negative perceptions, overwhelming anxiety and possibly thoughts of suicide which impact an individual's functioning in terms of roles and decision making.

Table 4

Depression/Anxiety of Chronically Mentally Ill Clients (N=100)

Variable	Number	Percentage
Depression - Anxiety		
No Difficulty	56	56.0
A Little	26	26.0
Moderate	8	8.0
Quite A Bit	6	6.0
Extreme	1	1.0
Missing	3	3.0

Surprisingly, table 4 revealed that fifty-six percent of the sample reported no difficulty dealing with depression and anxiety, and approximately twenty-six percent reported having a little difficulty dealing with feelings of depression and anxiety. Eight percent of the sample

recorded a moderate level of difficulty dealing with these emotions, while only one percent had extreme difficulty in this area.

Impulsive/Addictive Behavior

This component of decompensation entails high risk behaviors that result in drug/alcohol usage, sexual promiscuity and unprotected sexual activity or any type of behavior associated with danger or self harm. In addition, shoplifting is also included for this particular study.

Table 5

Impulsive/Addictive Behavior of Chronically Mentally Ill Clients (N=100)

Variable	Number	Percentage
Impulsive - Addictive Behavior		
No Difficulty	84	84.0
A Little	8	8.0
Moderate	4	4.0
Quite A Bit	2	2.0
Missing	2	2.0

Table 5 revealed that eighty-four percent of the respondents denied having any difficulty engaging in high risk behaviors or the misuse/abuse of alcohol/drugs. Two

percent of the sample did admit to engaging in high risk behaviors.

Psychosis

This facet of decompensation refers to any behaviors that may or may not impact functioning such as auditory, visual, tactile, and olfactory hallucinations, disorganized thinking, thought blocking, and bizarre behaviors.

Table 6

Psychosis of Chronically Mentally Ill Clients (N=100)

Variable	Number	Percentage
Psychosis		
No Difficulty	74	74.0
A Little	14	14.0
Moderate	7	7.0
Quite A Bit	3	3.0
Extreme	1	1.0
Missing	1	1.0

Table 6 revealed that seventy-four percent of the population reported no difficulty with symptoms of psychosis interfering with their ability to function. Presumably, their medications were making it possible for them to function effectively. Fourteen percent of the sample

reported a little difficulty in this area, while only four percent reported quite a bit/ extreme difficulty with psychosis symptoms in terms of their ability to function.

Basis 32 Average: Decompensation Factors

The Basis 32 Average is a combination of the five aforementioned factors. In addition to a frequency analysis, this combined average is utilized in upcoming crosstabulation with the independent variables in order to determine if there is a statistical significance at the .05 level.

Table 7

Basis 32 Average: Decompensation Factors of Chronically Mentally Ill Clients (N=100)

Variable	Number	Percentage
BASIS Mean		
No Difficulty	63	63.0
A Little	23	23.0
Moderate	7	7.0
Quite A Bit	1	1.0
Missing	6	6.0

Overall, table 7 revealed that sixty-three percent of the sample reported having no difficulty in their levels of functioning when all five areas were reviewed. It appears that thirty-one percent experienced a little to a moderate level of difficulty (23% and 7% respectively), when an average of the five functioning levels were examined. One percent admitted experiencing extreme difficulty, and information from six percent of the sample was missing.

Research Questions and Hypotheses

In this study, there were three research questions and three null hypotheses. Each hypothesis was restated and empirical evidence analyzed to determine whether or not the hypotheses should be rejected or accepted.

This section is an analysis of the first research question of the study. Data are presented in an effort to analyze the relationship between decompensation factors and alternative care structures of chronically mentally ill clients.

Relationship Between Selected Independent Variables and Decompensation Factors

This section provides a response to the first research question in the study. Data are presented on age group, gender, ethnicity, education level, employment status, marital status, and two selected subscales of decompensation factors. The two categories of decompensation factors for

this particular study are daily living skills and relation to self and others. These two particular decompensation factors were chosen because of their potential of being possible predictors of reintegration into the community and maintaining mental health which could stimulate satisfaction with the quality of life for the chronically mentally ill population.

Research Question 1: What is the relationship between the age group, gender, ethnicity, education level, employment status, marital status, and the decompensation factors (Daily Living Skills and Relationship to Self/Others) of chronically mentally ill clients?

Hypothesis 1: There is no relationship between age group, gender, ethnicity, education level, employment status, marital status, and the decompensation factors of chronically mentally ill clients.

The statistical tests used for this section were Pearson's correlation coefficient to determine the association between two variables approximating the direction and strength of a linear relationship and the

Chi-square test. The significance level for hypothesis testing was at the .05 level of significance.

In an effort to enhance the analysis of the data in this section, the five point continuum (no difficulty = 0 to extreme difficulty = 5) which measured whether or not consumers experienced difficulty with daily living skills and in relation to self and others was recoded to a two point continuum scale which measured whether or not consumers experienced no difficulty or some difficulty with two selected decompensation factors.

The five point continuum scale was recoded as follows: Consumers reporting no difficulty (no difficulty = 0) was recoded as consumers having no difficulty in level of functioning with daily living skills and relation to self and others; consumers reporting difficulty (a little difficulty = 1, moderate difficulty = 2, quite a bit of difficulty = 3, extreme difficulty = 4) was recoded as consumers experiencing difficulty in their level of functioning (some difficulty = 1) as it relates to daily living skills and relation to self and others. The result of the decoded scale was as follows: no difficulty = 0; some difficulty = 1. This scale was used in the analysis of data in this section.

Table 8 is a crosstabulation of age group and the living skills of mentally ill clients. It shows the association between age and the level of functioning

experienced in terms of living skills by mentally ill clients.

Table 8

Age Group of Clients By Daily Living Skills (N=99)

		Daily Living Skills					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Age Group	n	n	%	n	%	n	%
Under 25	1	4	4.1	0	0.0	4	4.1
25 - 34	2	8	8.2	6	6.1	14	14.3
35 - 44	3	22	22.4	20	20.4	42	42.9
45 - 54	4	17	17.3	7	7.1	24	24.4
55 - Over	5	10	10.2	4	4.1	14	14.3
Total		92	92.9	7	7.1	99	100.0

C = .23202, df = 4, P > = .23314

Table 8 indicates that of the 99 mentally ill clients, 20 or 20.4 percent of respondents in the age range of 35-44 experienced some difficulty with daily functional skills, and 22 or 22.4 percent of the respondents in the age range of 35-44 denied experiencing any level of difficulty with living skills.

When the Pearson's R test was applied, the null hypothesis was accepted. As shown in Table 8, the Pearson's R test revealed that there was not a statistically significant relationship (.23314) between age and living

skills of mentally ill clients at the .05 level of significance.

Table 9 is a crosstabulation of gender and the living skills of mentally ill clients. It shows the association between gender and the level of functioning experienced regarding living skills by mentally ill clients.

Table 9

Gender of Clients By Daily Living Skills (N=98)

		Daily Living Skills					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Gender	n	n	%	n	%	n	%
Male	1	29	29.6	25	25.5	54	54.1
Female	2	32	32.7	12	12.2	44	44.9
Total		61	62.2	37	37.7	98	100.0

Phi = .19519, df = 1, $P \geq .05333$

Table 9 indicates that of the 98 clients, 29 or 29.6 percent of the males denied that they experienced any difficulty in terms of daily living skills, and 32 or 32.7 percent of the females also denied difficulty as it related to daily functioning skills. Of the females, 12 or 12.2 percent experienced difficulty with daily living skills, and 25 or 25 percent of the male respondents indicated that they experienced difficulty with daily living skills. It was

determined that males experienced more difficulty with daily living skills than females in terms of daily living skills.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 9, the Pearson's R test revealed that there was not a statistically significant relationship (.05333) between gender and daily living skills of mentally ill clients at the .05 level of significance.

Table 10 is a crosstabulation of race and the living skills of mentally ill clients. It shows the association between race and the level of functioning experienced in terms of living skills by mentally ill clients.

Table 10

Ethnicity of Clients By Daily Living Skills (N=98)

		Daily Living Skills					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Ethnicity	n	n	%	n	%	n	%
African American	1	41	41.8	20	20.4	61	62.2
Caucasian	2	19	19.4	15	15.3	34	34.7
Asian	3	0	0.0	1	1.0	1	1.0
American Indian	4	1	1.0	1	1.0	2	2.0
Total		61	62.2	37	37.8	98	100.0

C = .17242, df = 3, P $\geq$ .39122

Table 10 indicates that of the 100 mentally ill clients, 20 or 20.4 percent of the African Americans experienced difficulty with living skills, and 41 or 41.8 percent of African Americans denied experiencing difficulty with living skills. Among the various racial groupings in the study, 19 or 19.4 percent of Caucasians experienced difficulty with living skills to a lesser degree, and 15 or 15.3 percent experienced some difficulty in relation to living skills.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 10, the Pearson's R test revealed that there was no statistically significant relationship (.39122) between race and functional living skills of mentally ill clients at the .05 level of significance.

Table 11 is a crosstabulation of educational level and the living skills of mentally ill clients. It shows the association between educational status and the level of functioning as it relates to living skills by mentally ill clients.

Table 11

Education Level of Clients By Daily Living Skills (N=98)

		Daily Living Skills					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Education Level	n	n	%	n	%	n	%
8th Grade or Less	1	8	8.2	3	3.1	11	11.3
Some High School	2	10	10.2	6	6.1	16	16.3
H.S. Graduate	3	25	25.5	11	11.2	36	36.7
Some College	4	15	15.3	10	10.2	25	25.5
Four Year College	5	3	3.1	7	7.1	10	10.2
Total		61	62.2	7	7.1	98	100.0

$C = .23613$, $df = 4$, $P \geq .21566$

Table 11 indicates that of the 98 clients, 11 or 11.2 percent of the respondents who were high school graduates experienced some difficulty with living skills, and 25 or 25.5 percent of the respondents who are high school denied experiencing any difficulty with daily living skills. Of the respondents who had less than four years of college education, 15 or 15.3 percent denied any difficulty with daily living skills, and 10 or 10.2 percent had experienced some level of difficulty with daily living skills.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 11, the Pearson's R test revealed that there was not a statistically significant relationship (.21566) between education level

and living skills of mentally ill clients at the .05 level of significance.

Table 12 is a crosstabulation of employment status and the living skills of mentally ill clients. It shows the association between employment status and the level of functioning as it relates to living skills by mentally ill clients.

Table 12

Employment Status of Clients By Daily Living Skills (N=98)

		Daily Living Skills					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Employment Status	n	n	%	n	%	n	%
Not Employed	1	57	58.2	22	22.4	79	80.6
Employed	2	4	4.1	15	15.3	19	19.4
Total		61	62.2	37	37.8	98	100.0

Phi = .41672, df = 1, $P \leq .00004$

Table 12 indicates that of the 98 clients, 22 or 22.4 percent of those unemployed experienced some difficulty with daily living skills, and 57 or 58.2 percent of those unemployed denied problems with daily living skills. It was determined that the clients who were unemployed experienced more difficulty with living skills than those employed.

When the Pearson's R test was applied, the null hypothesis was rejected. As shown in Table 12, the Pearson's R test revealed that there was a statistically significant relationship (.00004) between employment status and living skills of mentally ill clients at the .05 level of significance.

Table 13 is a crosstabulation of marital status and the living skills of mentally ill clients. It shows the relationship between marital status and the level of functioning experienced in terms of living skills of mentally ill clients.

Table 13

Marital Status of Clients By Daily Living Skills (N=95)

		Daily Living Skills					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Marital Status	n	n	%	n	%	n	%
Never Married	1	29	30.5	26	27.4	55	57.9
Married	2	6	6.3	2	2.1	8	8.4
Separated	3	1	1.1	5	5.2	6	6.3
Divorced	4	14	14.7	7	7.4	21	22.1
Widowed	5	5	5.3	0	0.0	5	5.3
Total		55	57.9	40	42.1	95	100.0

$C = .30924$, $df = 4$, $P \leq .03967$

Table 13 indicates that of the 95 clients, 26 or 27.4 percent of the respondents who were never married reported experiencing some level of difficulty with daily living skills, and 29 or 30.5 percent of the never married respondents denied any difficulty with daily living skills. Of the marital status categories, Table 13 indicated that the majority of clients in the never married category experienced the least amount of difficulty in relation to daily living skills.

When the Pearson's R test was applied, the null hypothesis was rejected. As shown in Table 13, the Pearson's R test revealed that there was a statistically significant relationship (.03967) between marital status and living skills of mentally ill clients at the .05 level of significance.

Table 14 is a cross tabulation of age group and relation to self and others. It shows a relationship between age group and relation to self and others, and it indicates whether or not there is an association between age group and relation to self and others.

Table 14

Age Group of Clients by Relation to Self/Others (N=97)

	Relation to Self/Others					
	No Difficulty		Some Difficulty		Row Total	
Variable	#	%	#	%	#	%
Age Group						
Under 25	3	3.1	1	1.0	4	4.1
25 - 34	7	7.2	6	6.2	13	13.4
35 - 44	19	19.6	23	23.7	42	43.3
45 - 54	17	17.5	8	8.2	25	25.8
55 - Over	9	9.3	4	4.1	13	13.4
Column Total	55	56.7	42	43.3	97	100.0

Missing observations: 3

Chi Square	Value	DF	Significance
Pearson's R	4.96792	4	.29061

As shown in Table 14, consumers in the 35-44 age grouping experienced more difficulty with relation to self and others, when compared to the younger or older age groups. Table 14 indicates 23 or 23.7% of those in the age range of 35-44 reported experiencing more difficulty with relation to self and others, compared to 8 or 8.2% of those in the age group of 45-54 and 6 or 6.2% of those in the 25-34 age group.

In a sample of 100, there were 97 valid observations. When Pearson's R test was applied, the null hypothesis was not rejected. This indicates that there was not a statistically significant relationship or association between age group and relation to self and others at the .05 level of significance.

Table 15 is a cross tabulation of gender and relation to self and others. It shows a relationship with gender and relation to self and others. In addition, it indicates whether or not there is an association between gender and relation to self and others.

Table 15

Gender of Clients by Relation to Self/Others (N=97)

	Relation to Self/Others					
	No Difficulty		Some Difficulty		Row Total	
Variable	#	%	#	%	#	%
Gender						
Male	24	24.7	29	29.9	53	54.6
Female	31	32.0	13	13.4	44	45.4
Column Total	55	56.7	42	43.3	97	100.0

Missing Observations: 3

Chi Square	Value	DF	Significance
Pearson's R	6.20451	1	.01274

As shown in Table 15, females reported experiencing less difficulty in relation to self and others when compared to the males. Table 15 indicates 31 or 32.0% of females experienced less difficulty in their perception of themselves and their relationships with others, compared to 24 or 24.7% of males in this category.

In a sample of 100, there were 97 valid observations. When Pearson's R test was applied, the null hypothesis was rejected. This indicates that there is a statistically significant relationship or association at the .05 level of significance.

Table 16 is a cross tabulation of ethnicity by relation to self and others. It shows a relationship with ethnicity and relation to self and others. In addition, it indicates whether or not there is an association between ethnicity and relation to self and others.

Table 16

Ethnicity of Clients by Relation to Self/Others (N=97)

	Relation to Self/Others					
	No Difficulty		Some Difficulty		Row Total	
Variable	#	%	#	%	#	%
Ethnicity						
African American	38	39.2	24	24.7	62	63.9
Caucasian	16	16.5	16	16.5	32	33.0
Asian			1	1.0	1	1.0
American Indian	1	1.0	1	1.0	2	2.1
Column Total	55	56.7	42	43.3	97	100.0

Missing Observations: 3

Chi Square	Value	DF	Significance
Pearson's R	2.46327	3	.48197

As shown in Table 16, African Americans experienced less difficulty with relation to self and others than Caucasians. Thirty-eight or 39.2% of African Americans experienced no difficulty in relation to self and others, as compared to 16 or 16.5% of Caucasians in this category of decompensation.

In a sample of 100, there were 97 valid observations. When Pearson's R test was applied, the null hypothesis was not rejected. This indicates that there was no

statistically significant relationship among ethnicity and relation to self and others at the .05 level of significance.

Table 17 is a cross tabulation of the level of education and relation to self and others. It shows a relationship between educational level and one's perception of how they relate to others. In addition, it indicates whether or not there is an association between the level of education and relation to self and others.

Table 17

Education Level of Clients by Relation to Self/Others (N=97)

	Relation to Self/Others					
	No Difficulty		Some Difficulty		Row Total	
Variable	#	%	#	%	#	%
Education Level						
8th Grade or Less	7	7.2	4	4.1	11	11.3
Some High School	9	9.3	6	6.2	15	15.5
High School Grad	21	21.6	15	15.5	36	37.1
Some College	15	15.5	10	10.3	25	25.8
4 Years College	3	3.1	7	7.2	10	10.3
Column Total	55	56.7	42	43.3	97	100.0

Missing Observations: 2

Chi Square	Value	DF	Significance
Pearson's R	3.33583	4	.50328

As shown in Table 17, those who graduated from high school reported experiencing more difficulty in relation to self and others when compared to those with more education or less education respectively. Fifteen or 15.5% of high school graduates reported experiencing some difficulty in relation to self and others, as compared to 10 or 10.3% of those with some college education, and 4 or 4.1% of those with an 8th grade or less education in this category of decompensation. In a sample of 100, there were 97 valid observations. When Pearson's R test was applied, the null hypothesis was not rejected. This indicates that there is no statistically significant relationship at the .05 level of significance.

Table 18 is a cross tabulation of the ability to function in employment and relation to self and others. It shows a relationship between employment and relation to self and others. In addition, it indicates whether or not there is an association between the level of function in employment and the relation to self and others.

Table 18

Employment Status of Clients by Relation to Self/Others (N=97)

	Relation to Self/Others					
	No Difficulty		Some Difficulty		Row Total	
Variable	#	%	#	%	#	%
Employment Status						
No Difficulty	49	50.5	29	29.9	78	80.4
Some Difficulty	6	6.2	13	13.4	19	19.6
Column Total	55	56.7	42	43.3	97	100.0

Missing Observations: 3

Chi Square	Value	DF	Significance
Pearson's R	6.07398	1	.01372

As shown in Table 18, those who reported having no difficulty with employment experienced less difficulty in relation to self and others. Forty-nine or 50.5% of those who reported having no difficulty in employment reported less difficulty in relation to self and others, while 6 or 6.2% of those who experienced some difficulty in employment and relation to self and others.

There were 97 valid observations out of a sample of 100. When Pearson's R test was applied, the null hypothesis was rejected. This indicates that there is a statistically

significant relationship between the level of functioning in employment and relation to self and others at the .05 level of significance.

Table 19 is a cross tabulation of marital status and relation to self and others. It shows a relationship between marital status and the perception of one's self and relationships with others. In addition, it indicates whether or not there is an association between marital status and relation to self and others.

Table 19

Marital Status of Clients by Relation to Self/Others (N=95)

	Relation to Self/Others					
	No Difficulty		Some Difficulty		Row Total	
Variable	#	%	#	%	#	%
Marital Status						
Never Married	29	30.5	26	27.4	55	57.9
Married	6	6.3	2	2.1	8	8.4
Separated	1	1.1	5	5.3	6	6.3
Divorced	14	14.7	7	7.4	21	22.1
Widowed	5	5.3			5	5.3
Column Total	55	57.9	40	42.1	95	100.0

Missing Observations: 5

Chi Square	Value	DF	Significance
Pearson's R	10.04566	4	.03967

As shown in Table 19, those who were never married reported experiencing less difficulty in relation to self and others when compared to those who were divorced. Twenty-nine or 30.5% of those who never married experienced less difficulty in relationships with others, while 14 or 14.7% of those who were divorced experienced difficulty in this category of decompensation.

In a sample of 100, there were 95 valid observations. When Pearson's R test was applied, the null hypothesis was rejected. This indicates that there is a statistically significant relationship between marital status and relation to self and others at the .05 level of significance.

In summary, when the six independent variables for the study were crosstabulated with two types of decompensation factors, 22 percent of clients in the age range of 35-44 experienced less difficulty with daily living skills. Females experienced more difficulty with daily living skills. Forty-one percent of African Americans experienced less difficulty with daily living skills.

Twenty-five percent of clients with a high school diploma experienced no difficulty with daily living skills. Fifty-seven percent of clients who reported no difficulty with employment, also denied difficulty with daily living skills. Thirty-four percent of clients who were married denied having problems with daily living skills. Nineteen percent of the individuals in the age range of 35-44 denied

difficulty with relation to self/others. Males reported more difficulty with relation to self/others. African Americans reported more difficulty with relation to self/ others than Caucasians. High school graduates reported the least amount of difficulty in relation to self/others. In terms of employment, 29 percent of these employed reported difficulty in relation to self/others. Twenty-seven percent of those individuals who were married reported difficulty in relation to self/others.

Alternative Care Structures

Alternative care structures are agencies which offer a wide array of program components inclusive of medication assistance, counseling, job placement, residential assistance in the form of: aftercare clinics, vocational rehabilitation centers, public health nursing services, foster family care, convalescent nursing homes, sheltered workshops, residential programs and partial hospitalizations.

Mental Health Center

This component of alternative care structure provides individual/family counseling and medication dispension and assistance. Some centers offer a day program which assists with job training, residential assistance and placement, in addition to coordinating other needed services.

Table 20

Mental Health Center Attendance and Utilization of Chronically Mentally Ill Individuals (N=100)

Variable	Number	Percentage
Mental Health Center		
Clinic Visits		
No Difficulty	74	74.0
A Little	10	10.0
Moderate	6	6.0
Quite A Bit	6	6.0
Extreme	4	4.0
Obtaining Needs		
No Difficulty	80	80.0
A Little	9	9.0
Moderate	4	4.0
Quite A Bit	5	5.0
Extreme	2	2.0
Psychotherapy		
No Difficulty	75	75.0
A Little	8	8.0
Moderate	6	6.0
Quite A Bit	4	4.0
Extreme	6	6.0
Missing	1	Missing

Clinic Visits

Twenty-four percent of the clients who attend the mental health center reported no difficulty with getting to and from the mental health follow-up appointments. Ten percent reported a little difficulty with their clinic visits. Six percent reported quite a bit of difficulty with attending follow-up appointments in addition to four percent who reported extreme difficulty in attending follow-up appointments.

Obtaining Medications

Eighty percent of the sample reported no difficulty obtaining their medications from the mental health center. Nine percent experienced a little difficulty obtaining their medications. Five percent experienced quite a bit of complications obtaining their medication. It is vital to note that many of the clients live in some form of supportive living environment and assistance is given with getting their medications. Only two percent experienced extreme difficulty getting their medications through the mental health centers.

Psychotherapy

Seventy-five percent of the respondents stated that they did not experience any difficulty with therapy sessions including their case manager or psychiatrist. Eight percent reported experiencing a little difficulty with their

therapist/doctor and six percent reported extreme difficulty.

Biopsychosocial Program

A program whose components provide prevocational training in various disciplines, such as clerical, maintenance, horticulture, and food service, in which the skills could be utilized for employment in the aforementioned arenas. In addition, socialization is provided to encourage leisure activities and relational interactions.

Table 21

Alternative Care Structure Program Components and Clients' Perception of Their Level of Functioning (N=100)

Variable	Number	Percentage
Biopsychosocial Program		
Day Program		
No Difficulty	75	75.0
A Little	8	8.0
Moderate	6	6.0
Quite A Bit	4	4.0
Extreme	7	7.0
Socialization		
No Difficulty	74	74.0
A Little	11	11.0
Moderate	9	9.0
Quite A Bit	2	2.0
Extreme	4	4.0
Biopsychosocial Program		
Employment		
No Difficulty	79	79.0
A Little	7	7.0
Moderate	2	2.0
Quite A Bit	3	3.0
Extreme	9	9.0

Day Program

Overwhelmingly, seventy-five percent of the sample did not experience any difficulty in the day program and found it to be a helpful aspect of their reintegration in the community. Seven percent reported experiencing extreme difficulty in attending and participating in the day program.

Socialization Program

Surprisingly, seventy-four percent of the sample reported doing well and being active in the socialization program. Four percent of the respondents reported that they experienced extreme difficulty participating in the socialization program.

Employment Program

Seventy-nine percent of the sample did not experience any difficulty in the employment program. Perhaps the various workshops and transitional employment programs helped to facilitate the clients' transition into the workforce.

Residential Facility

This agency assists with living arrangements in terms of placement in the following dwellings: group homes and personal care homes. Additionally, there were independent living residencies in which the grounds were supervised and

the tenants maintained their independence by doing their own cooking and laundry.

Table 22

Alternative Care Structure Program Components and Clients' Perception of Their Level of Functioning (N=100)

Variable	Number	Percentage
Residential Facility		
Group Home		
No Difficulty	92	92.0
A Little	4	4.0
Moderate	1	1.0
Quite A Bit	1	1.0
Extreme	2	2.0
Independent Living		
No Difficulty	85	85.0
A Little	9	9.0
Moderate	5	5.0
Missing	1	Missing

Residential Facility: Group Home

Ninety-two percent reported that they did not experience any difficulty residing in a group home and among the eight percent that did experience difficulty, two percent stated they had extreme trouble living in a group home.

Personal Care Home

Ninety-seven percent of those interviewed did not reside in a personal care home. Of the three percent that resided in a personal care home, one percent reported that they experienced extreme difficulty.

Independent Living

Eighty-five percent of those interviewed denied having any problems residing in semi-independent living quarters. Among the 14 percent who did experience difficulty, only 5 percent experienced moderate difficulty.

Vocational Rehabilitation

This component of alternative care consisted of programs that were designed to assist clients with employment, job counseling and job coaching, job training, and provide financial assistance for school including tuition, book fees and transportation allowance.

Table 23

Alternative Care Structure Services (N=100)

Variable	Number	Percentage
Vocational Rehabilitation		
Work		
No Difficulty	83	83.0
A Little	3	3.0
Moderate	1	1.0
Quite A Bit	4	4.0
Extreme	8	8.0
Missing	1	Missing
Counseling		
No Difficulty	82	82.0
A Little	4	4.0
Moderate	6	6.0
Quite A Bit	4	4.0
Extreme	4	4.0
Training		
No Difficulty	87	87.0
A Little	7	7.0
Moderate	2	2.0
Extreme	4	4.0

Table 23 is a frequency distribution of decompensation factors among mentally ill clients. It is an indication of the number of mentally ill clients who have none or some difficulty in their functioning level based on observed facets of decompensation.

Vocational Rehabilitation

Concerning work, eighty-three percent of those interviewed were not participants in the vocational rehabilitation program. Three percent of those who reported utilizing vocational rehabilitation stated that they have a little difficulty in the vocational program. Eight percent reported experiencing extreme difficulty in the vocational rehabilitation program.

Counseling

Eighty-two percent of the sample did not participate in the counseling sessions offered by vocational rehabilitation. Six percent of the sample experienced a moderate amount of difficulty utilizing counseling services under the vocational rehabilitation program.

Training

Eighty-seven percent of the sample did not participate or had difficulty in the training program offered by vocational rehabilitation. Seven percent of the respondents reported experiencing a little difficulty in the training sessions under vocational rehabilitation, and four percent

reported extreme difficulty with the training classes in the vocational rehabilitation program.

Relationship Between Age Group, Gender, Ethnicity, Education Level, Employment Status, Marital Status, and Alternative Care Structures

This section provides an analysis of the second research question in the study. Data are presented on age group, gender, ethnicity, education level, employment status, marital status and three kinds of alternative care structures. The three kinds of alternative care structures for this particular study are Biopsychosocial Program, Mental Health Center, and Residential Facility. These components were chosen because of their potential for being possible predictors of reintegration into the community which could stimulate satisfaction with the quality of life for the chronically mentally ill population.

Research Question 2: What is the relationship between age group, gender, ethnicity, education level, employment status, marital status and the alternative care structures of chronically mentally ill clients?

Hypothesis 2: There is no relationship between age group, gender, ethnicity, education level, employment status, marital status and the alternative care structures of chronically mentally ill clients?

Table 24 is a crosstabulation of age group and the biopsychosocial rehabilitation program. It shows the association between age and the level of functioning experienced in terms of a biopsychosocial program.

Table 24

Age Group of Clients By Biopsychosocial Program (N=100)

		Biopsychosocial Program					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Age Group	n	n	%	n	%	n	%
Under 25	1	4	4.0	0	0.0	4	4.0
25 - 34	2	10	10.0	4	4.0	14	14.0
35 - 44	3	31	31.0	12	12.0	43	43.0
45 - 54	4	21	21.0	4	4.0	25	25.0
55 - Over	5	11	11.0	3	3.0	14	14.0
Total		77	77.0	23	23.0	100	100.0

C = .16319, df = 4, P > = .60292

Table 24 indicates that of the 100 mentally ill clients, 12 or 12.0 percent of respondents in the age group of 35-44 experienced some difficulty functioning in a biopsychosocial program, and 31 or 31.0 percent of this particular age group denied experiencing difficulty functioning as it relates to a biopsychosocial program.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 24, the Pearson's R test indicated that there was not a statistically significant relationship (.60292) between age and functioning in a biopsychosocial program of mentally ill clients at the .05 level of significance.

Table 25 is a crosstabulation of gender and the level of functioning in a biopsychosocial rehabilitation program for mentally ill clients. It shows the association between gender and the level of functioning as it relates to biopsychosocial rehabilitation by mentally ill clients.

Table 25

Gender of Clients By Biopsychosocial Programs (N=100)

		Biopsychosocial Programs					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Gender	n	n	%	n	%	n	%
Male	1	39	39.0	16	16.0	55	55.0
Female	2	38	38.0	7	7.0	45	45.0
Total		77	77.0	23	23.0	100	100.0

Phi = .16001, df = 1, P > .10958

Table 25 indicates that of the 100 mentally ill clients, 39 or 39.0 percent of the males denied experiencing any difficulty functioning, and 16 or 16.0 percent of the males experienced difficulty functioning in a biopsychosocial rehabilitation program.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 25, the Pearson's R test revealed that there was no statistically significant relationship (.10958) between gender and functioning in a biopsychosocial program by mentally ill clients at the .05 level of significance.

Table 26 is a crosstabulation of race and a biopsychosocial program of mentally ill clients. It shows the association between race and the level of functioning

experienced in terms of a biopsychosocial program by mentally ill clients.

Table 26

Ethnicity of Clients By Biopsychosocial Program (N=100)

		Biopsychosocial Program					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Ethnicity	n	n	%	n	%	n	%
African American	1	49	49.0	13	13.0	62	62.0
Caucasian	2	26	26.0	9	9.0	35	35.0
Asian	3	1	1.0	0	0.0	1	1.0
American Indian	4	1	1.0	1	1.0	2	2.0
Total		77	77.0	23	23.0	100	100.0

C = .11800, df = 3, P > .70269

Table 26 indicates that of the 100 mentally ill clients, 13 or 13.0 percent of the African Americans respondents denied experiencing any difficulty functioning in a biopsychosocial program, and 49 or 49.0 percent of African Americans denied experiencing difficulty functioning as it related to the area. Of the various racial groupings, African Americans experienced the least amount of difficulty functioning at 49 or 49.0 percent as compared to 26 or 26.0 percent Caucasians in a biopsychosocial program.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 26, the Pearson's R test revealed that there was no statistically significant relationship (.70269) between race and the functioning level of mentally ill clients at the .05 level of significance.

Table 27 is a crosstabulation of education and the functioning level of mentally ill clients in a biopsychosocial rehabilitation program. It shows an association between the level of education and functioning experienced in a biopsychosocial program by mentally ill clients.

Table 27

Education Level of Clients By Biopsychosocial Program (N=100)

		Biopsychosocial Program					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Education Level	n	n	%	n	%	n	%
8th Grade or Less	1	11	11.0	0	0.0	11	11.0
Some High School	2	11	11.0	5	5.0	16	16.0
H.S. Graduate	3	29	29.0	9	9.0	38	38.0
Some College	4	19	19.0	6	6.0	25	25.0
Four Year College	5	7	7.0	3	3.0	10	10.0
Total		77	77.0	23	23.0	100	100.0

C = 2.0080, df = 4, P > .37943

Table 27 indicates that of the 100 clients, 29 or 29.0 percent of the high school graduates denied difficulty functioning in a biopsychosocial program, and 9 or 9.0 percent experienced difficulty functioning in a biopsychosocial program. Nineteen or 19.0 percent of the respondents who had a four year degree denied difficulty functioning in a biopsychosocial program, and 6 or 6.0 percent experienced difficulty functioning in a biopsychosocial program.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 27, the Pearson's R test revealed that there was not a statistically significant relationship (.37943) between education level and the ability to function in a biopsychosocial program for mentally ill clients at the .05 level of significance.

Table 28 is a crosstabulation of employment status and functioning of mentally ill clients in a biopsychosocial rehabilitation program. It shows the relationship between employment status and functioning experienced in a biopsychosocial program by mentally ill clients.

Table 28

Employment Status of Clients By Biopsychosocial Program (N=100)

		Biopsychosocial Program					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Employment Status	n	n	%	n	%	n	%
Not Employed	1	74	74.0	5	5.0	79	79.0
Employed	2	3	3.0	18	18.0	21	21.0
Total		77	77.0	23	23.0	100	100.0

Phi = .76834, df = 1, P < .00000

Table 28 indicates that of the 100 respondents, 74 or 74.0 percent of those unemployed denied experiencing any difficulty functioning in a biopsychosocial rehabilitation program, and 5 or 5.0 percent of those unemployed respondents admitted experiencing some level of difficulty functioning in a biopsychosocial rehabilitation program. Of the respondents who were employed, 18 or 18.0 percent experienced difficulty functioning in a biopsychosocial program, and 3 or 3.0 percent denied experiencing difficulty functioning in a biopsychosocial program.

When the Pearson's R test was applied, the null hypothesis was rejected. As shown in Table 28, the Pearson's R test revealed that there was a statistically significant relationship (.00000) between employment status

and biopsychosocial programs of mentally ill clients at the .05 level of significance.

Table 29 is a crosstabulation of marital status and the biopsychosocial rehabilitation program of mentally ill clients. It shows an association between marital status and the level of functioning experienced in terms of a biopsychosocial rehabilitation program.

Table 29

Marital Status of Clients By Biopsychosocial Program (N=98)

		Biopsychosocial Program					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Marital Status	n	n	%	n	%	n	%
Never Married	1	42	42.9	15	15.3	57	58.2
Married	2	7	7.1	1	1.0	8	8.2
Separated	3	4	4.1	2	2.0	6	6.1
Divorced	4	18	18.4	4	4.1	22	22.4
Widowed	5	4	4.1	1	1.0	5	5.1
Total		75	76.5	23	23.5	98	100.0

C = .12254, df = 4, P > .82770

Table 29 indicates that of the 98 clients, 15 or 15.3 percent of the respondents who were never married experienced difficulty with functioning in a biopsychosocial program, and 42 or 42.9 percent denied difficulty functioning in a biopsychosocial program.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 29, the Pearson's R test revealed that there was not a statistically significant relationship (.82770) between marital status and biopsychosocial program of mentally ill clients at the .05 level of significance.

Table 30 is a crosstabulation between age group and the usage of mental health centers. It shows the association between age and the usage of the mental health centers by mentally ill clients.

Table 30

Age Group of Clients By Mental Health Center (N=99)

		Mental Health Center Usage					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Age Group	n	n	%	n	%	n	%
Under 25	1	3	3.0	1	1.0	4	4.0
25 - 34	2	9	9.1	5	5.1	14	14.1
35 - 44	3	31	31.3	11	11.1	42	42.4
45 - 54	4	22	22.2	3	3.0	25	25.3
55 - Over	5	12	12.1	2	2.0	14	14.1
Total		77	77.8	22	22.2	99	100.0

C = .19460, df = 4, P < = .42018

Table 30 indicates that of the 100 mentally ill clients, 9 or 9.1 percent of the respondents between the age of 35-44 agreed that they experienced some difficulty with the usage of mental health centers and 31 or 31.3 percent of clients 35-44 disagreed that they experienced some difficulty utilizing services of the mental health center.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 30, the Pearson's R test indicated that there was not a statistically significant relationship (3.89663) between age and mental health center usage by mentally ill clients at the .05 level of significance.

Table 31 is a crosstabulation of gender and the usage of the mental health centers. It shows the association between gender and the level of difficulty utilizing the mental health centers by mentally ill clients.

Table 31

Gender of Clients By Mental Health Center (N=99)

		Mental Health Center Usage					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Gender	n	n	%	n	%	n	%
Male	1	39	39.4	16	16.2	55	55.6
Female	2	38	38.4	6	6.1	44	44.4
Total		77	77.8	22	22.2	99	100.0

Phi = .18472, df = 1, P > .06608

Table 31 indicates that of the 99 mentally ill clients, 39 or 39.4 percent of the males reported that they experienced no difficulty with attending the mental health center and 38 or 38.4 percent of the females experienced no difficulty utilizing the mental health center. Of the males, 16 or 16.2 percent experienced some difficulty and 6 or 6.1 percent of the females reported experiencing some difficulty with accessing services and attending the mental health center. It was determined that females experienced less difficulty than males in attending or utilizing mental health services.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 31, the Pearson's R test indicated that there was not a statistically significant relationship (.06608) between gender and mental health center usage of clients at the .05 level of probability.

Table 32 is a crosstabulation of race and the usage of mental health centers. It shows the association between race and the level of difficulty experienced by clients at the mental health center.

Table 32

Ethnicity of Clients By Mental Health Center (N=99)

		Mental Health Center Usage					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Ethnicity	n	n	%	n	%	n	%
African American	1	48	48.5	14	14.1	62	62.6
Caucasian	2	27	27.3	7	7.1	34	34.4
Asian	3	1	1.0	0	0.0	1	1.0
American Indian	4	1	1.0	1	1.0	2	2.0
Total		77	77.8	22	22.2	99	100.0

C = .11103, df = 3, P > .74446

Table 32 indicates that of the 99 mentally ill clients, 14 or 14.1 percent of African Americans reported experiencing some difficulty with mental health center usage and 7 or 7.1 percent of Caucasians reported experiencing some difficulty in utilizing the mental health center. It was determined that African Americans experienced more difficulty with accessing services from the mental health center than any other race.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 32, the Pearson's R test indicated that there was not a statistically significant relationship (.74446) between race

and mental health center usage by mentally ill clients at the .05 level of probability.

Table 33 is a crosstabulation of education and the mental health center usage. It shows the association of education with mental health center usage of the respondents and indicated the educational level of the respondent.

Table 33

Education Level of Clients By Mental Health Center (N=99)

		Mental Health Center Usage					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Education Level	n	n	%	n	%	n	%
8th Grade or Less	1	10	10.1	1	1.0	11	11.1
Some High School	2	10	10.1	6	6.1	16	16.2
H.S. Graduate	3	32	32.3	5	5.0	37	37.3
Some College	4	19	19.2	6	6.1	25	25.3
Four Year College	5	6	6.1	4	4.0	10	10.1
Total		77	77.8	22	22.2	99	100.0

C = .25275, df = 4, P > .14936

Table 33 indicates that of the 99 mentally ill clients, 6 or 6.1 percent of those clients who had some college level of education experienced some difficulty with mental health center usage and 19 or 19.2 percent of those clients with some college level of education reported experiencing no difficulty in utilizing the mental health center. It was

determined that respondents that held a four year college degree experienced less difficulty in utilizing mental health services than any other educational group.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 33, the Pearson's R test indicated that there was not a statistically significant relationship (.14936) between education level and difficulty of utilization of the mental health center by the clients.

Table 34 is a crosstabulation of employment status and level of difficulty experienced with mental health center usage of the respondents. It shows the association between employment status and the level of difficulty with mental health center usage of mentally ill clients.

Table 34

Employment Status of Clients By Mental Health Center (N=99)

		Mental Health Center Usage					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Employment Status	n	n	%	n	%	n	%
Not Employed	1	66	66.7	13	13.1	79	79.8
Employed	2	11	11.1	9	9.1	20	20.2
Total		77	77.8	22	22.2	99	100.0

Phi = .27567, df = 1, P > .00609

Table 34 indicates that of the 99 mentally ill clients, 66 or 66.7 percent of those clients who were employed reported no difficulty in utilizing the services of the mental health center and 13 or 13.1 percent of those unemployed reported that they experienced some difficulty. It was determined that clients who were unemployed experienced the least amount of difficulty in accessing services at the mental health center. Of the clients who were employed 11 or 11.1 percent reported no difficulty in utilizing services of the mental health center and 9 or 9.1 percent of those employed reported some difficulty in utilizing the mental health center.

When the Pearson's R test was applied, the null hypothesis was rejected. As shown in Table 34, the Pearson's R test indicated that there was a statistically significant relationship (.00609) between employment status and level of difficulty utilizing the mental health center of mentally ill clients at the .05 level of significance.

Table 35 is a crosstabulation of marital status and the level of difficulty experienced by clients in terms of usage of the mental health center. It shows the association between marital status and the usage of the mental health center by mentally ill clients.

Table 35

Marital Status of Clients By Mental Health Center (N=97)

		Mental Health Center Usage					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Marital Status	n	n	%	n	%	n	%
Never Married	1	43	44.3	13	13.4	56	57.7
Married	2	7	7.2	1	1.0	8	8.2
Separated	3	5	5.2	1	1.0	6	6.2
Divorced	4	17	17.5	5	5.2	22	22.7
Widowed	5	5	5.2	0	0.0	5	5.2
Total		77	79.4	20	20.6	97	100.0

C = .14103, df = 4, P > .74157

Table 35 indicates that of the 97 mentally ill clients, 43 or 44.3 percent of the respondents were not married and reported that they did experience difficulty with utilizing the mental health center and 13 or 13.4 percent of the respondents who were not married reported that they did experience some difficulty in accessing or utilizing the services at the mental health center. Table 35 further revealed that clients who were unmarried experienced less difficulty utilizing the mental health center than other marital status categories in this study.

When the Pearson's R test was applied, the null hypothesis was not rejected. As well, Table 35 shows that the Pearson's R test indicated that there was no

statistically significant relationship (.74157) between marital status and the usage of the mental health center by the clients at the .05 level of significance.

Table 36 is a crosstabulation of age group and the residential facility of mentally ill clients. It shows the association between age and the usage of the mental health centers by mentally ill clients.

Table 36

Age Group of Clients By Residential Facility (N=99)

		Residential Facility					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Age Group	n	n	%	n	%	n	%
Under 25	1	4	4.0	0	0.0	4	4.0
25 - 34	2	12	12.1	1	1.0	13	13.1
35 - 44	3	40	40.4	3	3.0	43	43.4
45 - 54	4	23	23.2	2	2.0	25	25.3
55 - Over	5	13	13.1	1	1.0	14	14.1
Total		92	92.9	7	7.1	99	100.0

C = .05898, df = 4, P > = .98669

Table 36 indicates that of the 99 mentally ill clients, 40 or 40.4 percent of the clients between the age range of 35-44 denied experiencing any difficulty in their residential facility, and 3 or 3.0 percent between the age range of 35-44 reported experiencing some level of

difficulty in their residential facility. It was determined that the clients in the 35-44 age range experienced the least amount of difficulty, with respect to residential facility, than any other age group.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 36, the Pearson's R test revealed that there was not a statistically significant relationship (.98669) between age and level of difficulty in a residential facility of mentally ill clients at the .05 level of significance.

Table 37 is a crosstabulation of gender and the residential facility of mentally ill clients. It shows the association between gender and the level of difficulty experienced in terms of residential facilities by mentally ill clients.

Table 37

Gender of Clients By Residential Facility (N=99)

		Residential Facility					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Gender	n	n	%	n	%	n	%
Male	1	50	50.5	5	5.1	55	55.6
Female	2	42	42.4	2	2.0	44	44.4
Total		92	92.9	7	7.1	99	100.0

Phi = .08811, df = 1, P > .38064

Table 37 indicates that of the 99 mentally ill clients, 50 or 50.5 percent of the males denied experiencing any difficulty in their residential facilities, and 42 or 42.4 percent of the females denied experiencing any difficulty in their residential facilities. Of the males, 5 or 5.1 percent did experience some difficulty in their residential facility, and 2 or 2.0 percent of the females experienced some level of difficulty in their residential facilities. It was determined that males experienced more difficulty in their residential facilities than females in this particular study.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 37, the Pearson's R test indicated that there was not a statistically significant relationship (.30864) between gender and the level of difficulty in a residential facility of mentally ill clients at the .05 level of probability.

Table 38 is a crosstabulation of race and the residential facility of mentally ill clients. It shows the association between race and the level of difficulty experienced in terms of residential facilities by mentally ill clients.

Table 38

Ethnicity of Clients By Residential Facility (N=99)

		Residential Facility					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Ethnicity	n	n	%	n	%	n	%
African American	1	57	57.6	5	5.1	62	62.6
Caucasian	2	33	33.3	1	1.0	34	34.3
Asian	3	1	1.0	0	0.0	1	1.0
American Indian	4	1	1.0	1	1.0	2	2.0
Total		92	92.9	7	7.1	99	100.0

C = .25108, df = 3, P > .08352

Table 38 indicates that of the 99 mentally ill clients, 57 or 57.6 percent of the African Americans respondents denied any difficulty functioning in a residential facility, and 5 or 5.1 percent reported experiencing difficulty functioning in a residential facility. It was determined that the African American respondents experienced the least amount of difficulty functioning in a residential facility than any other racial grouping.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 38, the Pearson's R test indicated that there was no statistically significant relationship (.08352) between race and level of

functioning in a residential facility of mentally ill clients at the .05 level of significance.

Table 39 is a crosstabulation of educational level and the residential facility of mentally ill clients. It shows the association of educational level and the level of difficulty experienced in terms of residential facilities by mentally ill clients.

Table 39

Education Level of Clients By Residential Facility (N=99)

		Residential Facility					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Education Level	n	n	%	n	%	n	%
8th Grade or Less	1	11	11.1	0	0.0	11	11.1
Some High School	2	14	14.1	2	2.0	16	16.2
H.S. Graduate	3	36	36.4	2	2.0	38	38.4
Some College	4	22	22.2	2	2.0	24	24.2
Four Year College	5	9	9.1	1	1.0	10	10.1
Total		92	92.9	7	7.1	99	100.0

C = .13837, df = 4, P > .74817

Table 39 indicates that of the 99 mentally ill clients, 36 or 36.4 percent of the high school graduates denied any difficulty in terms of functioning in their residential facility, and 2 or 2.0 percent of those high school graduates reported experiencing some difficulty in terms of

functioning in their residential facility. It was determined that the high school graduate clients experienced the least amount of difficulty as it relates to functioning in a residential facility when compared to the other levels of educational status.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 39, the Pearson's R test revealed that there was no statistically significant relationship (.74817) between the level of education and the level of functioning in a residential facility of mentally ill clients at the .05 level of significance.

Table 40 is a crosstabulation of employment status and the residential facility of mentally ill clients. It shows the relationship between the employment status and the level of difficulty in terms of residential facilities by mentally ill clients.

Table 40

Employment Status of Clients By Residential Facility (N=99)

		Residential Facility					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Employment Status	n	n	%	n	%	n	%
Not Employed	1	77	77.8	1	1.0	78	78.8
Employed	2	15	15.2	6	6.1	21	21.2
Total		92	93.0	7	7.1	99	100.0

Phi = .43522, df = 1, P < .00002

Table 40 indicates that of the 99 mentally ill clients, 77 or 77.8 percent of the clients who were unemployed denied having any difficulty in residing in the residential facility, and 15 or 15.2 percent of those employed denied having any difficulty in their residential facility. Of the clients employed, 6 or 6.1 percent admitted experiencing some difficulty in their residential facility, and 1 or 1.0 percent of the unemployed clients admitted some difficulty in terms of their residential facility. It was determined that clients who were unemployed reported the least level of difficulty in their residential facility.

When the Pearson's R test was applied, the null hypothesis was rejected. As shown in Table 40, the Pearson's R test indicated that there was a statistically significant relationship (.00002) between employment status

and the level of difficulty experienced in a residential facility by mentally ill clients at the .05 level of significance.

Table 41 is a crosstabulation of marital status and the residential facility of mentally ill clients. It shows the association between marital status and the level of difficulty experienced in terms of residential facilities by mentally ill clients.

Table 41

Marital Status of Clients By Residential Facility (N=97)

		Residential Facility					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Marital Status	n	n	%	n	%	n	%
Never Married	1	50	51.5	6	6.2	56	57.7
Married	2	8	8.2	0	0.0	8	8.2
Separated	3	6	6.2	0	0.0	6	6.2
Divorced	4	21	21.6	1	1.0	22	22.7
Widowed	5	5	5.2	0	0.0	5	5.2
Total		90	92.8	7	7.2	97	100.0

C = .16561, df = 4, P > .60303

Table 41 indicates that of the 97 mentally ill clients, 51 or 51.5 percent of the never married respondents denied experiencing any difficulty functioning in their residential facility, and 6 or 6.2 percent reported experiencing some

difficulty functioning in their residential facility. It was determined that the never married respondents experienced the least amount of difficulty functioning in their residential facility. Of the marital status categories, Table 41 indicated that those respondents in the never married category experienced the least amount of difficulty functioning in residential facilities.

When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 41, the Pearson's R test revealed that there was no statistically significant relationship (.60303) between marital status and the level of functioning in a residential facility of mentally ill clients at the .05 level of probability.

Table 42 is a cross tabulation between Basis 32 average and alternative care structure. It shows the association between decompensation factors' mean average and usage of alternative care structures by mentally ill clients.

Table 42

Basis 32 Average Decompensation Factors By Alternative Care Structures (N=93)

		Usage of Alternative Care Structures					
Value Label	Value	No Difficulty		Some Difficulty		Row Total	
Basis 32 Mean	n	n	%	n	%	n	%
No Difficulty	0	61	65.6	1	1.1	62	66.7
Some Difficulty	1	19	20.4	12	12.9	31	33.5
Total		80	86.0	13	14.0	93	100.0

Phi =.50431 df=1 $p \leq .00000$

Table 42 indicates that of the 93 mentally ill clients, 61 or 65.6 percent of clients who experienced no difficulty in utilizing services of alternative care structures also experienced no difficulty with decompensation factors. It was determined that those who tended to utilize alternative care structures did not experience difficulty functioning. When the Pearson's R test was applied, the null hypothesis was not rejected. As shown in Table 42, the Pearson's R test indicated that there was not a statistically significant relationship (23.65240) between decompensation factors and care structures of mentally ill clients at the .05 level of significance.

Multiple Regression Analysis of the Basis 32 Average Decompensation Factors of Chronically Mentally Ill Clients (N=100)

In order to gain a better understanding of the impact of decompensation factors, multiple regression analysis was conducted to determine which factor had a greater degree of predictability. In examining the correlation between decompensation factors, the facet of living skills and daily functioning, and relationships to self and others, had the highest degree of predictability. As indicated in Table 43, Multiple Regression Analysis was executed. The variable living skill and daily role functioning emerged as the best predictor of decompensation. Consequently, 86 percent of the variation in decompensation factors could be explained by living skills and daily role functioning.

Table 43

Stepwise Multiple Regression of Care Structures

Variable	B	SEB	Beta	F	Sign F
Vocational Rehabilitation	.499920	.033118	.838794	222.859	.0000
(Constant)	.015333	.028972		.280	.5979

R Square = .70357 Sign F = .0000

As indicated in Table 43, Stepwise Multiple Regression was executed. The variable, Vocational Rehabilitation, emerged as the best predictor of alternative care structure (R Square = .70357, F < .0000). Table 43 indicated that 70 percent of the variation in alternative care structure could be explained by vocational rehabilitation.

Table 44

Stepwise Multiple Regression of Care Structures

Variable	B	SE B	Beta	F	Sign F
Mental Health Center	.202021	.031851	.358536	40.230	.0000
(Constant)	.024742	.025215		.963	

R Square = .79176 Sign F = .0000

As indicated in Table 44, stepwise multiple regression was executed, the mental health center was the second highest predictor of the usage of alternative care structures (R square = .792, F = < .0000). Table 44 shows that 79 percent of the variation of care structures can be explained by the variable mental health center.

In summary, as shown in Tables 43 and 44, the variables vocational rehabilitation and mental health center emerged as the best predictors of alternative care structure usage by the mentally ill population. Seventy percent of the

variation of care structure can be explained by vocational rehabilitation and seventy-nine percent can be explained by mental health centers.

Table 45

Stepwise Multiple Regression of Care Structures

Variable	B	SE B	Beta	F	Sign F
Living Skills	.654852	.040184	.861804	265.568	.0000
(Constant)	.028441	.043272		.432	

R Square = .74271 Sign F = .0000

Table 45 shows that sixty-five percent of the variation of decompensation factors can be explained by the variable living skills.

Table 46

Stepwise Multiple Regression of Decompensation Factors By Chronically Mentally Ill Clients (N=100)

Variable	B	SE B	Beta	F	Sign F
Impulse	.380833	.060021	.352641	40.259	.0000
(Constant)					

R Square = .82162 Sign F = .0000

Table 46 shows that 82 percent of the variation of decompensation factors can be explained by the variable impulsive/addictive behaviors.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

The research study was designed to answer three questions related to decompensation factors and alternative care structures of mentally ill clients in the metropolitan Atlanta area. The conclusions, which are premised on the research findings of the study, are presented in this chapter.

A brief discussion of each question is presented in order to summarize the significant findings of interest. In addition, recommendations were presented in an effort to stimulate and promote additional research related to decompensation factors and alternative care structures of the mentally ill population.

Research Question 1: Is there a relationship between decompensation factors and alternative care structures of chronically mentally ill clients?

To determine whether or not there was a statistically significant relationship between decompensation factors and alternative care structures, the Pearson's R test was employed. Results from the Pearson's R test indicated that

there was no statistically significant relationship (.00000) at the .05 level of significance between decompensation factors and alternative care structures of mentally ill clients. The null hypothesis was not rejected. Therefore, it was concluded that there was not a statistically significant relationship between decompensation factors and alternative care structures.

Overall, the data indicated that a majority of the 93 mentally ill clients, 61 or 65.6 percent agreed that they did not experience any difficulty with decompensation factors and alternative care structures, while 19 or 20.4 percent experienced some difficulty with decompensation factors and alternative care structures. In addition, 12 or 12.9 percent experienced some difficulty with alternative care structures and decompensation factors. Therefore it is concluded that there was not a statistically significant relationship between decompensation factors and alternative care structures.

Research Question 2: Is there a relationship between age group, gender, ethnicity, marital status, employment status, educational level, employment status and selected decompensation factors of chronically mentally ill clients?

To determine whether or not there was a statistically significant relationship between age group, gender, ethnicity, marital status, education level, employment status, and selected decompensation factors of mentally ill clients in the metropolitan Atlanta area, the Pearson's R test was employed. Results from the Pearson's R test indicated that of the six independent variables identified in this study, gender and employment status rejected the null hypothesis at the .05 level of significance. Therefore, in terms of decompensation factors, females experienced less difficulty with daily living skills than their male counterparts, and those who were employed experienced less difficulty with daily living skills.

Regarding the "relation to self and others" category, results from the Pearson's R test revealed that gender, employment and marital status were the three independent variables which rejected the null hypothesis at the .05 level of significance. Thus, females experienced less difficulty in relation to self and others than males. Those who experienced no difficulty with employment also experienced no difficulty in relation to self and others. In addition, those who were never married experienced less difficulty in relation to self and others.

Research Question 3: Is there a relationship between the age group, gender, ethnicity, education level, employment status, and marital status of selected alternative care structures?

To determine whether or not there was a statistically significant relationship between age group, gender, ethnicity, education level, employment status, and marital status and selected alternative care structures of mentally ill clients in the metropolitan Atlanta area, the Pearson's R test was employed. Of the six independent variables identified, employment status was the only variable which was identified which indicated a statistically significant relationship between the level of functioning in a biopsychosocial program and employment status. Consumers who experienced difficulty in employment also experienced difficulty functioning in a biopsychosocial program.

Employment status was identified as the only independent variable which indicated a statistically significant relationship in utilizing services of the mental health center and functioning in a residential facility. Clients who experienced no difficulty in employment experienced less problems in utilizing services of the mental health center and in a residential facility.

In summation, the findings of the study indicated that:

1) There was not a statistically significant relationship between decompensation factors and alternative care structures of mentally ill clients;
2) There was a statistically significant relationship between gender and daily living skills;
3) There was a statistically significant relationship between employment status and daily living skills;
4) There was a statistically significant relationship between gender and relation to self and others;
5) There was a statistically significant relationship between employment status and relation to self and others;
6) There was a statistically significant relationship between marital status and relation to self and others;
7) There was a statistically significant relationship between employment status and functioning in a biopsychosocial program;
8) There was a statistically significant relationship between employment status and the utilization of mental health services; and
9) There was a statistically significant relationship between employment status and level of functioning in a residential facility.

Finally, it was determined that the best predictors of alternative care structures, based on the stepwise multiple regression analysis, were vocational rehabilitation and mental health center. For vocational rehabilitation, the coefficient of determination (R square = .70357) indicated that 70 percent of the variation in the variable could be explained or predicted. Secondly, for mental health centers, the coefficient of determination (R square = .79176) indicated that 79 percent of the variation in the variable could be explained or predicted.

Recommendations

The scholarly examination of decompensation factors and the facets of alternative care structures which have an impact on service delivery are integral in order to ensure optimal functioning for the mentally ill in the community. It is mandatory in providing care for this growing population despite the advent of managed care and reduction of funding, the closing of State Psychiatric facilities and the era of managed care. The policy of deinstitutionalization is not contributing to chronicity among the mentally ill population. The policy of deinstitutionalization has not failed. As social workers guided by the themes of empowerment, advocacy and transformation we are called upon to instill these integral components to ensure quality services and improve the quality of life for our clientele.

Consequently, it is imperative that social workers in the field of mental health engage in research and the development of social policy via administrative positions to empower, advocate for, and transform in an effort to promote and maintain quality care, in addition to services for the growing mentally ill population who will be residing in the community and need special services in order to experience tenure in the community.

It is essential that social workers get involved on a legislative level to promote and assist in the passage of bills which mandate quality care services and program evaluations to ensure service delivery effectiveness. It is vital that social workers educate the public about mental illness and available resources. It is imperative that social workers assist clients in attaining their full potential in an effort to increase their quality of life and their tenure in their community.

APPENDIX A

LETTER TO PARTICIPANTS

A Comparitive Study of the RelationshipBetween Decompensation Factors
and Alternative Care Structures Regarding the Quality of Life
For the Mentally Ill

Survey Questionnaire

Thank you for your time and cooperation in completing the following questionnaire. I am currently a student in a Doctoral program at Clark Atlanta University. The purpose of the following study in which you are about to embark is to learn more about the quality of life and alternative care structures. Due to the confidentiality of our participants, please do not put your name on the questionnaire. Choose only one answer for each question and please respond to all questions. Once again, thank you in advance for your participation.

Michelle Miles

I ----------have read the aforementioned statement about this research project and I voluntarily agree to answer all questions to the best of my ability. I understand that the responses will be utilized for scholastic purposes and that the original questionaire will be turned in to the staff of Community Friendship as part of their quality assurance procedure. I can choose to rescind my participation by notifiying the student at a time not to exceed 30 days from the date of my signature.

Date_____.

What is your primary diagnosis?

1) ___ Schizophrenia
2) ___ Depression
3) ___ Manic Depression
4) ___ Anxiety Disorder
5) ___ Schizoaffective Disorder
6) ___ Personality Disorder
7)___ Unknown

APPENDIX B

BASIS-32 BEHAVIOR AND SYMPTOM IDENTIFICATION SCALE

FOR OFFICE USE ONLY Site code ☐☐☐

INSTRUCTIONS TO STAFF: Please write the respondent's Identification Number and Visit Number, one digit in each box. Fill in the Visit Type and Level of Care using the code numbers below.

Identification Number ..... ☐☐☐☐☐☐☐☐☐

Visit Number ..... ☐☐☐☐☐☐☐

Visit Type..... 1 = Admission/Intake; 2 = Mid-Treatment; 3 = Discharge/Termination; 4 = Post-Treatment Follow-up ☐

Level of Care..... 1 = Inpatient; 2 = Outpatient; 3 = Partial Hospital/Day Treatment... ☐

BASIS-32™
BEHAVIOR AND SYMPTOM IDENTIFICATION SCALE

INSTRUCTIONS TO RESPONDENT: Below is a list of problems and areas of life functioning in which some people experience difficulties. Using the scale below, fill in the box with the answer that best describes how much difficulty you have been having in each area during the PAST WEEK.

0 = No difficulty
1 = A little difficulty
2 = Moderate difficulty
3 = Quite a bit of difficulty
4 = Extreme difficulty

Please respond to each item. Do not leave any blank. If there is an area that you consider to be inapplicable, indicate that it is *No Difficulty*.

IN THE PAST WEEK, how much difficulty have you been having in the area of:

1. Managing Day-to-Day Life. (For example, getting places on time, handling money, making everyday decisions)..... 1 ☐
2. Household Responsibilities. (For example, shopping, cooking, laundry, cleaning, other chores)..... 2 ☐
3. Work. (For example, completing tasks, performance level, finding/keeping a job). 3 ☐
4. School. (For example, academic performance, completing assignments, attendance). 4 ☐
5. Leisure time or recreational activities..... 5 ☐
6. Adjusting to major life stresses. (For example, separation, divorce, moving, new job, new school, a death)..... 6 ☐
7. Relationships with family members..... 7 ☐
8. Getting along with people outside of the family..... 8 ☐

PLEASE TURN PAGE TO CONTINUE.

APPENDIX B

(continued)

0 = No difficulty
1 = A little difficulty
2 = Moderate difficulty
3 = Quite a bit of difficulty
4 = Extreme difficulty

9. Isolation or feelings of loneliness..... 9 ☐
10. Being able to feel close to others..... 10 ☐
11. Being realistic about yourself or others..... 11 ☐
12. Recognizing and expressing emotions appropriately..... 12 ☐
13. Developing independence, autonomy..... 13 ☐
14. Goals or direction in life..... 14 ☐
15. Lack of self-confidence, feeling bad about yourself..... 15 ☐
16. Apathy, lack of interest in things..... 16 ☐
17. Depression, hopelessness..... 17 ☐
18. Suicidal feelings or behavior..... 18 ☐
19. Physical symptoms (For example, headaches, aches and pains, sleep disturbance, stomach aches, dizziness)..... 19 ☐
20. Fear, anxiety or panic..... 20 ☐
21. Confusion, concentration, memory..... 21 ☐
22. Disturbing or unreal thoughts or beliefs..... 22 ☐
23. Hearing voices, seeing things..... 23 ☐
24. Manic, bizarre behavior..... 24 ☐
25. Mood swings, unstable moods..... 25 ☐
26. Uncontrollable, compulsive behavior (For example, eating disorder, hand-washing, hurting yourself)..... 26 ☐
27. Sexual activity or preoccupation..... 27 ☐
28. Drinking alcoholic beverages..... 28 ☐
29. Taking illegal drugs, misusing drugs..... 29 ☐
30. Controlling temper, outbursts of anger, violence..... 30 ☐
31. Impulsive, illegal or reckless behavior..... 31 ☐
32. Feeling satisfaction with your life..... 32 ☐

APPENDIX B

(continued)

For the following questions, please write the response code in the appropriate box.

33. How old were you on your last birthday?.....33 ☐

34. What is your sex?.....34 ☐
1 = Male **2 = Female**

35. What is your race?.....35 ☐
1 = Black/African-American **4 = American Indian/Alaskan**
2 = White/Caucasian **5 = Other**
3 = Asian/Pacific Islander

36. Are you Hispanic or Latino?.....36 ☐
1 = Yes **2 = No**

37. What is your marital status?.....37 ☐
1 = Never married **4 = Divorced**
2 = Married **5 = Widowed**
3 = Separated

38. How much school have you completed?..... 38 ☐
1 = 8th grade or less **4 = Some college**
2 = Some high school, but did not graduate **5 = 4-year college graduate**
3 = High school graduate or GED

39. In the past 30 days, what were your usual living arrangements?.....39 ☐
1 = Alone **4 = With non-relative**
2 = Halfway house/group home/hospital **5 = Shelter/Street**
3 = With family/With domestic partner **6 = Other**

40. In the past 30 days, were you working at a paid job?.....40 ☐
1 = Yes **2 = No**

41. If yes, how many hours per week? (If no, leave blank).....41 ☐
1 = 1 - 10 hours **3 = 21 - 30 hours**
2 = 11 - 20 hours **4 = More than 30 hours**

42. In the past 30 days, were you a student attending a high school, vocational training program, college or graduate degree program?..... 42 ☐
1 = Yes **2 =No**

43. Today's Date.....43 ☐☐ ☐☐ ☐☐
MONTH **DAY** **YEAR**

APPENDIX C

ALTERNATIVE CARE STRUCTURE SURVEY

Section II **Alternative Care Structure Survey**

Instructions: Below is a list of alternative care structures in which some people experience difficulties. Using the scale below, fill in the box with the answer that best describes how much difficulty you have been having in each area during the **past week.**

0 = No difficulty
1 = A little difficulty
2 = Moderate difficulty
3 = Quite a bit of difficulty
4 = Extreme difficulty

Please respond to each item. Do not leave any blank. If there is an area that you consider to be inapplicable, indicate that it is ***No difficulty.***

IN THE PAST WEEK, how much difficulty have you been having in the area of:

44. Clinic Visit. ..... **44** ☐

45. Obtaining Medications ..... **45** ☐

46. Psychotherapy ..... **46** ☐

47. Day program ..... **47** ☐

48. Socialization ..... **48** ☐

49. Employment ..... **49** ☐

50. Group home ..... **50** ☐

51. Personal Care Home ..... **51** ☐

52. Independent Living ..... **52** ☐

53. Work ..... **53** ☐

54. Counseling ..... **54** ☐

55. Training ..... **55** ☐

APPENDIX D

MCLEAN BASIS 32 ANALYSIS DATA LIST


```
->   TITLE 'McLEAN BASIS 32 ANALYSIS - MICHELLE MILES DISSERTATION'
->
->   DATA LIST
->    FIXED / ID 1-3
 >    Q1 4
 >    Q2 5
->    Q3 6
->    Q4 7
->    Q5 8
->    Q6 9
->    Q7 10
->    Q8 11
->    Q9 12
->    Q10 13
->    Q11 14
->    Q12 15
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->    Q35 38
->    Q36 39
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->    Q40 43
->    Q41 44
->    Q42 45
->    Q43 46
->    Q44 47
->    Q45 48
->    Q46 49
->    Q47 50
->    Q48 51
->    Q49 52
->    Q50 53
```

APPENDIX D

(continued)


```
->    Q51 54
->    Q52 55
 >    Q53 56
->    Q54 57
->    Q55 58.
```

This command will read 1 records from the command file

Variable	Rec	Start	End	Format
ID	1	1	3	F3.0
Q1	1	4	4	F1.0
Q2	1	5	5	F1.0
Q3	1	6	6	F1.0
Q4	1	7	7	F1.0
Q5	1	8	8	F1.0
Q6	1	9	9	F1.0
Q7	1	10	10	F1.0
Q8	1	11	11	F1.0
Q9	1	12	12	F1.0
Q10	1	13	13	F1.0
Q11	1	14	14	F1.0
Q12	1	15	15	F1.0
Q13	1	16	16	F1.0
Q14	1	17	17	F1.0
Q15	1	18	18	F1.0
Q16	1	19	19	F1.0
Q17	1	20	20	F1.0
Q18	1	21	21	F1.0
Q19	1	22	22	F1.0
20	1	23	23	F1.0
Q21	1	24	24	F1.0
Q22	1	25	25	F1.0
Q23	1	26	26	F1.0
Q24	1	27	27	F1.0
Q25	1	28	28	F1.0
Q26	1	29	29	F1.0
Q27	1	30	30	F1.0
Q28	1	31	31	F1.0
Q29	1	32	32	F1.0
Q30	1	33	33	F1.0
Q31	1	34	34	F1.0
Q32	1	35	35	F1.0
Q33	1	36	36	F1.0
Q34	1	37	37	F1.0
Q35	1	38	38	F1.0
Q36	1	39	39	F1.0
Q37	1	40	40	F1.0
Q38	1	41	41	F1.0
Q39	1	42	42	F1.0
Q40	1	43	43	F1.0
Q41	1	44	44	F1.0
Q42	1	45	45	F1.0
Q43	1	46	46	F1.0

APPENDIX D

(continued)


```
Q44          1      47      47        F1.0
Q45          1      48      48        F1.0
 46          1      49      49        F1.0
Q47          1      50      50        F1.0
Q48          1      51      51        F1.0
Q49          1      52      52        F1.0
Q50          1      53      53        F1.0
Q51          1      54      54        F1.0
Q52          1      55      55        F1.0
Q53          1      56      56        F1.0
Q54          1      57      57        F1.0
Q55          1      58      58        F1.0

->
->   COMPUTE SELFOTH=(Q7+Q8+Q10+Q11+Q12+Q14+Q15)/7.
->   COMPUTE DEPRESS=(Q6+Q9+Q17+Q18+Q19+Q20)/6.
->   COMPUTE LIVSKILL=(Q1+(Q2+Q3+Q4/3)+Q5+Q13+Q16+Q21+Q32)/7.
->   COMPUTE IMPULSE=(Q25+Q26+Q28+Q29+Q30+Q31)/6.
->   COMPUTE PSYCHOT=(Q22+Q23+Q24+Q27)/4.
->   COMPUTE BASMEAN=(Q1+Q2+Q3+Q4+Q5+Q6+Q7+Q8+Q9+Q10+Q11+Q12+Q13+Q14+Q15+Q16+Q17+Q18
->   +Q19+Q20+Q21+Q22+Q23+Q24+Q25+Q26+Q27+Q28+Q29+Q30+Q31+Q32)/32.
->   COMPUTE MHCENTER=(Q44+Q45+Q46)/3.
->   COMPUTE BIOPRO=(Q47+Q48+Q49)/3.
->   COMPUTE RESFAC=(Q50+Q51+Q52)/3.
->   COMPUTE VOCREHAB=(Q53+Q54+Q55)/3.
->   COMPUTE CARESTRU=(Q44+Q45+Q46+Q47+Q48+Q49+Q50+Q51+Q52+Q53+Q54+Q55)/12.
->
->   VARIABLE LABELS
->   ID 'Case'
->   SELFOTH 'Relation to self and others subscale'
 >   DEPRESS 'Depression-anxiety subscale'
->   LIVSKILL'Daily living skills subscale'
->   IMPULSE 'Impulseive-addictive behavior subscale'
->   PSYCHOT 'Psychosis subscale'
->   BASMEAN 'Basis 32 Average'
->   Q33 'AGE GROUP'
->   Q34 'GENDER'
->   Q35 'RACE'
->   Q36 'HISPANIC'
->   Q37 'MARITAL STATUS'
->   Q38 'EDUCATION'
->   Q39 'LIVING ARRANGEMENT'
->   Q40 'PAID JOB PAST 30 DAYS'
->   Q41 'WORK HOURS PER WEEK'
->   Q42 'ATTEND SCHOOL PAST 30 DAYS'
->   Q43 'INTERVIEW SESSION'
->   Q44 'CLINIC VISIT'
->   Q45 'OBTAINING MEDICATIONS'
->   Q46 'PSYCHOTHERAPY'
->   Q47 'DAY PROGRAM'
->   Q48 'SOCIALIZATION'
->   Q49 'EMPLOYMENT'
->   Q50 'GROUP HOME'
->   Q51 'PERSONAL CARE HOME'
```

APPENDIX D

(continued)

```
28-Feb-:0 McLEAN BASIS 32 ANALYSIS - MICHELLE MILES DISSERTATION          Page 4

->    Q52 'INDEPENDENT LIVING'
->    Q53 'WORK'
 >    Q54 'COUNSELING'
->    Q55 'TRAINING'
->    MHCENTER 'Mental health center'
->    BIOPRO 'Bio-psycho-social program'
->    RESFAC 'Residential facility'
->    VOCREHAB 'Vocational rehabilitation'
->    CARESTRU 'Alternative care structure'.
->
->    VALUE LABELS
->    SELFOTH
->     0 'No difficulty'
->     1 'A little'
->     2 'Moderate'
->     3 'Quite a bit'
->     4 'Extreme'/
->    DEPRESS
->     0 'No difficulty'
->     1 'A little'
->     2 'Moderate'
->     3 'Quite a bit'
->     4 'Extreme'/
->    LIVSKILL
->     0 'No difficulty'
->     1 'A little'
->     2 'Moderate'
->     3 'Quite a bit'
->     4 'Extreme'/
->    IMPULSE
 >     0 'No difficulty'
->     1 'A little'
->     2 'Moderate'
->     3 'Quite a bit'
->     4 'Extreme'/
->    PSYCHOT
->     0 'No difficulty'
->     1 'A little'
->     2 'Moderate'
->     3 'Quite a bit'
->     4 'Extreme'/
->    BASMEAN
->     0 'No difficulty'
->     1 'A little'
->     2 'Moderate'
->     3 'Quite a bit'
->     4 'Extreme'/
->    MHCENTER
->     0 'No difficulty'
->     1 'A little'
->     2 'Moderate'
->     3 'Quite a bit'
->     4 'Extreme'/
->    BIOPRO
```

APPENDIX D

(continued)


```
->    0 'No difficulty'
->    1 'A little'
 >    2 'Moderate'
->    3 'Quite a bit'
->    4 'Extreme'/
->   RESFAC
->    0 'No difficulty'
->    1 'A little'
->    2 'Moderate'
->    3 'Quite a bit'
->    4 'Extreme'/
->   VOCREHAB
->    0 'No difficulty'
->    1 'A little'
->    2 'Moderate'
->    3 'Quite a bit'
->    4 'Extreme'/
->   CARESTRU
->    0 'No difficulty'
->    1 'A little'
->    2 'Moderate'
->    3 'Quite a bit'
->    4 'Extreme'/
->   Q33
->   1 'Under 25'
->   2 '25 - 34'
->   3 '35 - 44'
->   4 '45 - 54'
->   5 '55 - over'/
->   Q34
 >   1 'Male'
->   2 'Female'/
->   Q35
->   1 'African American'
->   2 'Caucasian'
->   3 'Asian'
->   4 'American Indian'
->   5 'Other'/
->   Q36
->   1 'YES'
->   2 'NO'/
->   Q37
->   1 'Never married'
->   2 'Married'
->   3 'Seperated'
->   4 'Divorced'
->   5 'Widowed'/
->   Q38
->   1 '8th grade or less'
->   2 'Some high school'
->   3 'HS graduate or GED'
->   4 'Some college'
->   5 '4 yr College graduate'/
->   Q39
```

APPENDIX D

(continued)


```
->   1 'Alone'
->   2 'Group home etc.'
 >   3 'With family'
->   4 'With nonrelative'
->   5 'Shelter-street'
->   6 'Other'/
->   Q40
->   1 'Yes'
->   2 'No'/
->   Q41
->   0 'Not Working'
->   1 '1 - 10 hours'
->   2 '11- 20 hours'
->   3 '21 - 30 hours'
->   4 'More than 30 hours'/
->   Q42
->   1 'Yes'
->   2 'No'/
->   Q43
->   1 'First visit'
->   2 'Follow-up visit'/
->   Q44
->    0 'No difficulty'
->    1 'A little'
->    2 'Moderate'
->    3 'Quite a bit'
->    4 'Extreme'/
->   Q45
->    0 'No difficulty'
->    1 'A little'
 >    2 'Moderate'
->    3 'Quite a bit'
->    4 'Extreme'/
->   Q46
->    0 'No difficulty'
->    1 'A little'
->    2 'Moderate'
->    3 'Quite a bit'
->    4 'Extreme'/
->   Q47
->    0 'No difficulty'
->    1 'A little'
->    2 'Moderate'
->    3 'Quite a bit'
->    4 'Extreme'/
->   Q48
->    0 'No difficulty'
->    1 'A little'
->    2 'Moderate'
->    3 'Quite a bit'
->    4 'Extreme'/
->   Q49
->    0 'No difficulty'
->    1 'A little'
```

APPENDIX D

(continued)


```
->     2 'Moderate'
 >     3 'Quite a bit'
->     4 'Extreme'/
->    Q50
->     0 'No difficulty'
->     1 'A little'
->     2 'Moderate'
->     3 'Quite a bit'
->     4 'Extreme'/
->    Q51
->     0 'No difficulty'
->     1 'A little'
->     2 'Moderate'
->     3 'Quite a bit'
->     4 'Extreme'/
->    Q52
->     0 'No difficulty'
->     1 'A little'
->     2 'Moderate'
->     3 'Quite a bit'
->     4 'Extreme'/
->    Q53
->     0 'No difficulty'
->     1 'A little'
->     2 'Moderate'
->     3 'Quite a bit'
->     4 'Extreme'/
->    Q54
->     0 'No difficulty'
 >     1 'A little'
->     2 'Moderate'
->     3 'Quite a bit'
->     4 'Extreme'/
->    Q55
->     0 'No difficulty'
->     1 'A little'
->     2 'Moderate'
->     3 'Quite a bit'
->     4 'Extreme'/.
->    MISSING VALUES
->    Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q10 Q11 Q12 Q13 Q14 Q15 Q16 Q17 Q18 Q19 Q20
->    Q21 Q22 Q23 Q24 Q25 Q26 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34 Q35 Q36 Q37 Q38
->    Q39 Q40 Q41 Q42 Q43 Q44 Q45 Q46 Q47 Q48 Q49 Q50 Q51 Q52 Q53 Q54 Q55 (9).
->    RECODE SELFOTH DEPRESS LIVSKILL (0 THRU 0.99=0) (1 THRU 1.99=1) (2 THRU
->    2.99=2) (3 THRU 3.99=3) (4 THRU 4.99=4).
->    RECODE IMPULSE PSYCHOT BASMEAN (0 THRU 0.99=0) (1 THRU 1.99=1) (2 THRU 2.99=2)
->    (3 THRU 3.99=3) (4 THRU 4.99=4).
->    RECODE MHCENTER BIOPRO RESFAC (0 THRU 0.99=0) (1 THRU 1.99=1) (2 THRU 2.99=2)
->    (3 THRU 3.99=3) (4 THRU 4.99=4).
->    RECODE VOCREHAB CARESTRU (0 THRU 0.99=0) (1 THRU 1.99=1) (2 THRU 2.99=2) (3
->    THRU 3.99=3) (4 THRU 4.99=4).
->    RECODE Q44 Q45 Q46 Q47 Q48 Q49 (0 THRU 0.99=0) (1 THRU 1.99=1) (2 THRU 2.99=2)
->    (3 THRU 3.99=3) (4 THRU 4.99=4).
->    RECODE Q50 Q51 Q52 Q53 Q54 Q55 (0 THRU 0.99=0) (1 THRU 1.99=1) (2 THRU 2.99=2)
```

APPENDIX D

(continued)


```
->   (3 THRU 3.99=3) (4 THRU 4.99=4).
->   BEGIN DATA
->   00100440400000044040140444000000003212152212100000440440 0
->   00210110231231212312211220020300212312214120210021200000 21
->   00300000000000000000000000000000003112133202100000000000 0
->   00400000010010100110020000000000024112433201100000000000 0
->   00500211100000020111002010000000100212213322210001100000 00
->   00600000100110000111011000000000003212336201110000000000 0
->   00700000000000000000000000000000003112144202100000000000 0
->   00821331231123112341243312333122231211212313211324010043 31
->   00900002403000000043003310320400200311221420110000000000 0
->   01000000100100000012012402000000000311214220214040040004 44
->   01100000220111210100092110020000100422213311110001000000 00
->   01232424444444424044444444444404334211213120213442400000 40
->   01322220022444330110003001300100013122133112100111100100 0
->   01401232211233110122011110030000103321242320210002000010 00
->   01520000112000101000010000010000000522243122210001110010 00
->   01611101111121111000012010000000000112213213210000000000 0
->   01700000111111111111001110000000002212213212210000000000 0
->   01810001211010000110000000000000001412243422210000000000 0
->   01900110000000000000000000000000000421213411210000000000 0
->   02000000202340322001042100010000023212134202100001000000 0
->   02101000000211001000030000000000024212144202100020000000 0
->   02210131421422432334233424230031424311232212210001140004 00
->   02322222233123410412344344321002403521212420214343200043 00
->   02430000000000010000100000000000031121341321000000000000 0
->   02500000000000000000000000000000041124342221000000000000 0
->   02600000000000000000000000000000031121442021000000000000 0
->   02700000000000000001010000000000005212514222100000000000 0
->   02800000230110100003043000020000101321214314210130000001 30
->   02900001001000009110001101000000100512242420211110001000 00
->   03011300000000000020100000000000014212226201111100001000 0
->   03120010200101100021030000000000002122133202100110000000 0
->   03211110201001001101000100000000002222143201100010000900 0
->   03321002012999922222012110011200012212213311210000140004 00
->   03401001001000000000000000000000400421252213210001111001 00
->   03511211211221223223133330131001103212213320213331200010 21
->   03600000010110100001011002000000102321212320110001000000 00
->   03700000000010000000000000000000002212236201100000000001 1
->   03800000000000011010010100000000005212421122100000000000 0
->   03920300001400100100010100000000100111213320110000000000 0
->   04000010100100001001001001110000000421212512210001000000 00
->   04120323342442112234343344344440424314244120213132430043 02
->   04200000000000000000000000000000004222412202100000000000 0
->   04320322101132101211030001003110001311214112211011210010 00
->   04411341312121121111221244131191102311213220210000000000 0
->   04500000000332300002232111000000002311245120210000000000 0
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->   04710001101333110122023300000000002522222112210000220000 0
->   04800000000000000000000000000000005222213132100000000000 0
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->   05010000000010000000011010000000001421254620210000000000 0
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->   05202000000212012130001000000000002522244111210100000000 0
```

APPENDIX D

(continued)


```
->   05311320421233214211011230320130122312215620212141040004 34
->   05440403001221310100110000000110000413213519110000100000 10
->   05522012242222122231111220222000003312243420210224240004 22
->   05600100112122301121143320131030411321213120210000330000 00
->   05711101011100000110001010000000000521242211210000000000 00
->   05810300242001110112013304020000001322215220210000000000 00
->   05911004444440410004044404340000400221234620214440000000 00
->   06000000000000000000000000010000000211214213210000000000 00
->   06100000000000000000000000000000003222412202100000000000 00
->   06240003401443333333133223020000002521231220212000000000 00
->   06310000121230100000010100000000000311214220211000000000 00
->   06401390000011122100030111000010001411213120210000133412 01
->   06500000000000100011010100000000100321213220210000000000 00
->   06600000000000000000200000000000003212131201100000000000 00
->   06700000001000000000010000000000005112532202100000000000 00
->   06800000000000000000000000000000005242541202100000000000 00
->   06900000000000100000010000000000002112141132100000000000 00
->   07022222222999999999999999999999932221321221439002001300
->   07111111111211233323212200122000233122132202100000000000 00
->   07200300120000200011011210010000000412244120210000000000 00
->   07300000040401000211101100004000025112312202100000000000 00
->   07400000100200001100011010010410001311214211211000000000 00
->   07503104402340111204043200010003204421234114210000400000 40
->   07610200201121211011211220121000124112246122100000000001 0
->   07723203411322244233103300023010014412245212212220200000 20
  >  07800000000000000000000000000000003212451201100000000000 00
->   07900000110001100000010011111010000411241212210000000000 00
->   08010301443342113333343211133100102312214120213033344004 34
->   08110240431223144101011000000200004411213211210000140044 40
->   08223404111233333331042233222300002311214220212020110001 11
->   08313132331122032021031300021200002412214213210020200000 21
->   08410300100432010224200000000002000211211121212200000000 00
->   08520440224333301221020110000000000321295220211111000000 00
->   08600000000000000000040000000000004222254202100000000000 00
->   08722003000333334433033320023200003412293220212200002000 00
->   08840444444444444401100044044400414311245111113344440106 24
->   08910020131110002111001101010100101311211520210000000010 00
->   09010000000111131001021110010000100522412202100000000000 00
->   09101120400000101000100000100100000422114911110000000000 00
->   09201000020000110101011124010400000411212220210001000000 00
->   09340000000110400224014444000410004311212220211110000000 00
->   09400003232222000100033233010000100321213612213000000000 00
->   09510000040010000000001000000200000312242212210000000000 00
->   09620000000101100011022000000000000321214220210000000000 00
->   09700000120000000000101100001000001212131122100000000000 00
->   09812102020133311200001120001000002322245211210000201000 00
->   09900000400000000000020000004200004322223222210000001000 00
->   10010000101101100000011100010000000211213322210000000000 00
->   END DATA.
->   FREQUENCIES /VARIABLES Q33 Q34 Q35 Q36 Q37 Q38 Q39 Q40 Q41 Q42 Q43
->   /STATISTICS =.

There are 498,520 bytes of memory available.
 he largest contiguous area has 498,520 bytes.
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